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THE UNIVERSITY OF ALBERTA

SUICIDE AND THE ROLE OF THE COMMUNITY GATEKEEPER

by

DARLENE BAYERS

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A THESIS
SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH
IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE
OF MASTER OF EDUCATION
IN

COUNSELLING PSYCHOLOGY

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FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research, for acceptance, a thesis entitled "Suicide and the Role of the Community Gatekeeper," submitted by Darlene Bayers in partial fulfilment of the requirements for the degree of Master of Education in Counselling Psychology.

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ABSTRACT

This thesis explored the role of the community gatekeeper in interactions with suicidal clients. The outcome of the study was the development of a training program, based on a synthesis of the literature review and the results of a questionnaire. This four part questionnaire initially requested demographic data from the respondents. The second section, employing the semantic differential technique, asked subjects to rate their attitudes to four concepts (completed suicide, life, death and attempted suicide) along seven evaluative dimensions. The following section queried the gatekeepers on their personal expiences with suicide, utilizing parts of Shneidman's survey on "You and Death." Finally, the bulk of the questionnaire was composed of questions, exploring the experiences, needs and recommendations of practising community gatekeepers. The questionnaire was given to two groups of subjects, those attending a two day introductory conference on suicide prevention and those attending a two day advanced workshop on suicide prevention, held immediately following the conference. Out of 267 possible subjects, 97 (36%) chose to respond to the questionnaire. Results revealed that respondents were predominantly negative in their attitudes to suicide and these attitudes were influenced by the gatekeepers' religiosity, occupation and death wishes. Gatekeepers also appear to be, for the most part, personally familiar with suicide. Discussion of both the influences on attitude toward suicide and the gatekeepers' past personal experiences with suicide was seen as a necessary component of any training program for gatekeepers. Respondents' concerns, resulting from the fourth part of the questionnaire, were combined with the emphasis of the literature review to produce a proposed training program. This flexible program was structured around an introductory conference on suicide prevention followed by two series of workshops, one occupation-specific and the other subject-specific. The thesis concluded with suggestions for further research, emphasizing the need to expand the numbers of community gatekeepers by education and re-education of the general public.

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TABLE OF CONTENTS

CHAPTER PAGE

I INTRODUCTION 1

II LITERATURE REVIEW 7

- Attitudes Toward Suicide 7
- Training of Gatekeepers 12
- Case Management of Suicidal Clients 15
  - Recognition 16
  - Assessment 19
  - Intervention 21
    - Theories of Suicide 22
    - Crisis Intervention 24
    - Intervention with Special Groups 26
      - Adolescents 26
      - The Elderly 27
      - Children 28
      - Chronically suicidal 28
- Gatekeeper Groups 30
  - Crisis Center Workers 30
  - Medical Personnel (Specialized Cases) 35
  - Psychotherapists 42
  - Doctors (Non-psychiatric) 52
  - Nurses 54
  - Policemen 58
  - Clergymen 59

CHAPTER PAGE

Summary 61

III METHODOLOGY 64

Description of the Sample 64

Semantic Differential 69

Shneidman's Survey 75

Questions 76

IV FINDINGS AND DISCUSSION 78

Semantic Differential 78

Shneidman's Survey 91

Questions 97

Summary 119

V LIMITATIONS AND RECOMMENDATIONS 121

Limitations 121

Proposed Training Program 122

Implications for Further Research 129

REFERENCES 131

REFERENCE NOTES 152

APPENDIX A: Gatekeepers 154

APPENDIX B: Covering Letter: Conference Group 158

APPENDIX C: Covering Letter: Workshop Group 160

APPENDIX D: Questionnaire 162

LIST OF TABLES

TABLE PAGE

1 Total Group: Demographic Data 65

2 List of Suicide Prevention Occupation Types 67

3 Total Group Participants and Questionnaire Respondents by Occupational Type 68

4 List of One-way ANOVAs Performed 74

5 Factor Loading Matrix 80

6 Factor 1: Means and Newman-Keuls Comparisons for Four Concepts 82

7 Factor 2: Means and Newman-Keuls Comparisons for Four Concepts 83

8 Factor 3: Means and Newman-Keuls Comparisons for Four Concepts 84

9 Religiosity: Attitudes to "Attempted Suicide"—Factor 3 86

10 Occupation: Attitudes to "Completed Suicide"—Factor 3 87

11 Wanted to Die: Attitudes to "Completed Suicide"—Factors 1, 2 and 3 88

12 Wanted to Die: Attitudes to "Attempted Suicide"—Factor 1 89

13 Attitudes Toward Death and Suicide: A Comparison of Two Samples 92

14 Shneidman's Sample vs Present Sample: Differences in Responses—Chi-Square Tests 95

LIST OF FIGURES

FIGURE		PAGE
1	Rates of Suicide in Alberta: 1968-1976	4
2	Known Completed Suicides in Last Year: Group T . . .	100
3	Number of Suicidal People Seen in One Year: Group T .	106

CHAPTER I

INTRODUCTION

In suicide literature and jargon the prime community agent in suicide intervention and postvention (and to varying degrees, prevention) is called a "gatekeeper." Snyder (1971) appears to have been the first to use the term in reference to crisis intervention and his definition included all those in the community to whom troubled people turned for help. As Snyder put it, "The person who stands at the gate may give a great deal of help, he may give very little help, or he may close the gate in the face of the troubled person" (p. 39). The term "gatekeeper" was further clarified by Resnik and Hathorne (1973):

> Perhaps the backbone of suicide prevention in America has been the GATEKEEPER, who actually interacts with the majority of suicidal individuals, provides crisis first-aid, and matches the needs of his clients with available community resources. (p. 35)

"Gatekeeper" as used in the present study, was seen as a suitable word with neither positive nor negative connotation. (For a fuller discussion on the origin and difficulties with the term "gatekeeper" see Appendix A.)

Suicide as a topic for concern, discussion, and research has increasingly become an issue of sizable proportions; witness three bibliographies since 1969: Farberow, 1969a, 1972a; Prentice, 1974. The problem is admittedly, a complex one. Authors have, again and again, been caught up in trying to define and categorize suicide in a theoretically sound, yet practicably feasible fashion (Pokorny, 1974; Shneidman, 1970c). Most writers in the field agree with the World Health Organization (WHO) definition of suicide as "the self-infliction of injury with varying degrees of lethal intent and awareness of motive" (Allodi & Eastwood, 1973, p. 15). However, most authors, this writer among them, also agree with Pokorny (1974) and Shneidman (1970c) that the definition of suicide as a human behavior is broadening to include a continuum of self-destructive behaviors. The certainty of the observer, lethality, intent, and mitigating circumstances of the act itself have to be taken into account in determining the presence, absence or degree of suicidal behavior. Hence, the more questions are asked, the greater is the demand put on research to grope for answers concerning this complex human behavior. Shneidman (1968) has given emphasis to the current core issue of suicide research:

> It may well be that the word suicide currently has too many loose and contradictory meanings to be scientically or clinically useful. What has been confusing . . . is that the individual has been viewed as a kind of biological object (rather than psychological, social, biological organism), and as a consequence, the role of the individual in his own demise has been omitted. (pp. 23-25)

Whatever the difficulties of definition, suicide as a problem needing answers exists, now. The suicide rate in Canada was at 11.3 per 100,000 population in 1970, a definite increase over the 1950 figure of 7.8 per 100,000 population (Allodi & Eastwood, 1973). Individual provinces, such as Ontario, have reported increases in both numbers and rates of suicide; for Ontario 1,277 persons committed suicide in

1975, an increase of 76% from 1965; the population of the province increased only 22% during the comparable time period ("Study reveals drop," 1976). More pertinent to this study, Alberta in 1976 reported a suicide rate of 16.5 ("Youth suicide rate," 1979); moreover, a noticeable increase has been seen in the rate of suicide in the province over the last eight years (see Figure 1).

In 1974 the provincial government established the Task Force on Suicides in Alberta. This body was to gather information on suicide (including carrying out its own research), to review the information with particular reference to Alberta, and to make recommendations for governmental consideration. In a Report published in 1976 the Task Force stated:

> Suicide is a complex social phenomenon which requires a variety of social responses. To effect a reduction in the current rate of suicide and non-accidental self-injury will require a comprehensive approach on three levels: prevention, intervention and postvention and at each level, effective long-term reduction in suicidal behavior requires sociologically, psychologically and medically oriented approaches. (Report, 1976, p. 1)

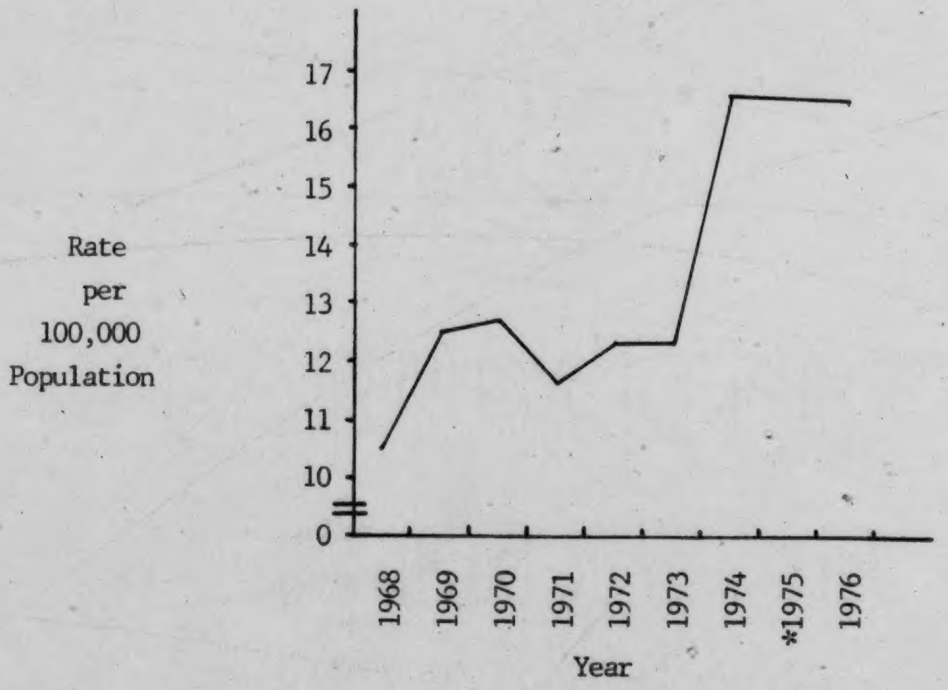
The Report (1976) and an Interim Report (Solomon & Boldt, Note 1) focused on the need for special training in suicide prevention, intervention and postvention based on the belief that intervention can be effective, a belief supported by many engaged in research on suicidal behavior (Farberow, 1968a; Hatton, Valente, & Rink, 1977; Resnik & Hathorne, 1973; Stengel, 1973).

The Report (1976) went on to point out that there were very few individuals trained for suicide intervention in the province, and that no organization existed with the mandate to undertake such training.

FIGURE 1

RATE OF SUICIDE IN ALBERTA

1968 - 1976



* Figures not available.

Sources: Report of the Task Force on Suicides in Alberta, 1976, p. 292; "Youth suicide rate," 1979, p. 83.

The present system for suicide prevention in Alberta was limited in a number of other ways: by a disorganized referral system, by poor record-keeping, by inadequate standards and staffing, by neglect of volunteer resources, by little emphasis on outreach, by neglect of rural areas and by the critical problem of funding. However, little was known about actual gatekeepers now working in Alberta; the Report (1976) only surveyed social service agencies in the province, finding that 91.6% of the agencies reporting had no workers with significant training in suicide prevention.

Moreover, in research on suicidal behavior, the critical role of the community gatekeeper has not been adequately studied. A review of the literature in Chapter II will demonstrate this further. As in any social interaction, for the dynamics of the situation to be fully understood, both parties to the relationship, as well as the social-psychological forces operating withing the relationship itself must be examined. That such a study of the role of one of the key figures in suicide intervention is important is supported by Hatton, et al. (1977):

> The caregiver, like the client, is a human being with a set of values, principles, and behaviors inherent, or learned in coping with the surrounding world. Often the caregiver will attempt to repress these feelings and behaviors in an effort to maintain objectivity in approaching a client. (p. 33)

Proper training depends on accurate knowledge of the role of the gatekeeper. This thesis will attempt to examine the role of community gatekeepers and their emotional and behavioral involvement with suicidal clients.

Chapter III will examine the method used in this study to obtain data about the gatekeeper. A four part questionnaire (Appendix D) was used. The sections of the questionnaire and the various statistical methods that were employed will be presented.

Chapter IV will give the results obtained from the data and will attempt to reflect trends that were observed in the answering of the questionnaires. Primarily, the responses to questions will be examined for indications that may influence any future training procedures for community gatekeepers.

Chapter V will attempt to put the results into meaningful perspective primarily in regards to training procedures and content. This chapter will also present implications for further research in the area, taking into account any limitations in the present research.

CHAPTER II

LITERATURE REVIEW

In this chapter, with a view towards illuminating what is known about gatekeepers, information and research relating to gatekeepers will be presented in four sections. The first will deal with societal and gatekeeper attitudes toward suicide. The following section will accent the paucity of training methods available. The third section concerns present methods of case management of suicidal clients. The concluding section will deal with the various gatekeeper groups as presented in the literature on suicide.

Attitudes Toward Suicide

Research has been done on primarily two aspects of attitudes toward suicide. The first part of the research covers societal experiences with, beliefs about, and attitudes toward suicide. The second group of studies encompasses research about specific groups, how and why they react to suicide and how they differ in their attitudes and/or responses to suicide.

Attitudes to suicide by a general population began to be studied in an oblique manner by Kostrubala and McInerney (1966), as part of a larger probe into the incidence of suicide in Chicago. For many city officials, "unless a death [could] be proven definitely to be suicide, eg., by the discovery of a specific suicidal communication, it [was] listed under 'other causes'" (p. 122). This negative attitudinal set was encountered again and again as the authors attempted to carry out their questioning. The position was defended by city officials as based on humanitarian and economic grounds directed toward survivors.

Noyes (1968) sought to explore the cultural bases for such a negative view of suicide. For Noyes, present conventional reactions and prejudices are deeply rooted in primitive superstition; suicide poses a threat of death to the living.

In Nevada, Ginsburg (1971b) sought to explore how personally experienced the general public was with suicide. In a survey of 208 households, 53% of those surveyed knew someone who had committed suicide, and 21% had someone in the immediate family or inlaws who had committed or attempted suicide. Ginsburg also found that most people (62%) believed that those who threatened suicide would not commit it. Further, 56% believed that people do not have the right to take their own life; 60% felt that people attempting did not really want to die; 55% believed that the suicidal person was mentally ill and 66% would feel ashamed if someone in their family committed a suicidal act.

Other researchers examined questions similar to those of Ginsburg, pertaining to public experience with suicide. Shneidman's (1970d, 1971) survey, with an impressive 30,000 person sample, found that 60% of the respondents had wanted to die at some time in their life and 53% had seriously considered killing themselves, while 13% had actually attempted suicide. Kalish, Reynolds and Farberow (1972, 1974) in Los Angeles interviews with 400 people found that the sample tended to believe that suicidal people were either mentally ill or in a temporary state of psychological stress (guilt and/or frustration). Again, Paykel, Myers, Lindenthal, and Tanner (1974) reported suicidal feelings in 8.9% of 720 respondents. Those who felt suicidal also reported more minor psychiatric symptoms, mainly depressive in nature; social isolation (not interacting as much with friends and neighbors); life stress (more significant life events) and more somatic illnesses and medical treatment. These three broad studies appear to confirm that societal belief systems influence and are influenced by certain attitudes toward suicidal people.

Three smaller scale studies parallel the findings of the larger projects. Seiden and Teitler (1972) compared subjects' attitudes to people who had committed suicide and to those who had died accidental, homicidal or natural deaths. Coupled with a reluctance to respond to a story about a suicidal person, the sample population viewed suicidal people as less independent, less normal, less adventurous, less brave, less pleasant, more sensitive, more disturbed and more dependent than people who had died by other modes. Further, Potkay, Jackson, and McTeague (1973) found that people seeing suicidal characters in a play (Quiet Cries) rated suicidal people consistently more negatively than the concept "Me." Sale, Williams, Clark, and Mills (1975) again found predominantly negative attitudes toward suicide in two communities; those in the community which reported contact with attempted suicides were found more likely to hold negative attitudes, to be under 35 years of age, and to regard the act as manipulative and due to mental illness. Sale, et al. (1975) also reported a difference in the two suburbs interviewed; where the rate of suicide was higher, a more negative attitude toward suicide prevailed. The authors concluded that contact with attempted suicide tended to be associated with an unfavorable attitude toward the suicide attempter.

The results of the studies of public reaction to suicide tend to be paralleled by results of research with specific groups involved with suicidal populations. Further, these smaller group studies begin to focus more clearly on variables that affect attitudes toward suicide.

Beswick (1970), in a pilot study, disclosed that doctors were more tolerant of suicide than clergy, police, ex-soldiers, soldiers and nurses; the Catholic clergy were most strongly opposed. As well, Catholics were significantly more opposed to suicide than were Protestants and Agnostics. Ansel and McGee (1971) were more specific in the focus of their research, stating clearly:

> A suicide attempt creates negative attitudes in others, and thus the helper often responds to the attempter with hostility and rejection, perhaps failing to effect a change desired by the attempter, which was the reason for the attempt. (p. 22)

Thus, Ansel and McGee, as well as trying to demonstrate negativity of attitudes, also tried to differentiate among groups (psychiatric residents, psychiatric nurses, emergency room personnel, volunteers, police and the lay public). However, although the number of responses was fairly small and no differences were found between groups, negative attitudes predominated. Moreover, the less the perceived degree of intention to die, the more negative was the attitude toward the attempter.

A comparison study (Weis & Seiden, 1974) contrasted volunteers in a suicide prevention center and suicide attempters using the same center in attitudes to suicide. As opposed to suicide attempter volunteers had greater emotional stability, much less fantasy about suicide, almost no actual suicide attempts and a disinclination to consider suicide as a justifiable problem-solving option.

Ramon, Brancroft, and Skrimshire (1975) further developed Ansel and McGee's (1971) theme:

> As in making our clinical judgments we rely a great deal on the accounts patients give to us, it is important to understand how our attitudes and those of our colleagues may influence these accounts. It may also influence the likelihood of the act being repeated. (p. 262)

Their research concerned nurses' and doctors' responses to four case histories. Nurses were more accepting, more sympathetic, more likely to see the act of suicide as a manifestation of, or escape from distress. Nurses were also more likely than doctors, in circumstances similar to that of a given case study of a person who completed the act of suicide, to seek professional help for themselves. For both nurses and doctors, a depressive motive, as opposed to a manipulative one, was more likely to be acceptable and to elicit help.

Beginning with Ansel and McGee (1971), followed by Ramon, et al, (1975) and then by Dressler, Prusoff, Mark, and Shapiro (1975), studies have attempted to identify the interplay of caregiver and suicidal attempter. Dressler, et al (1975) found that the characteristics of patients who provoked the most negative attitude on the part of psychiatric residents were patients with many previous attempts, a slow rate of suicidal onset, a high lethality and intent, and where a high risk continued after the initial interview.

Similarly, Nichol (1976) investigated factors affecting the negativity of attitudes toward suicide. Nichol found that the subjects' attitudes toward suicide attempters were influenced by the perceived degree of stress on the attempter. As well, males who were suicidal, but under less stress were seen more negatively than females under similar circumstances. Under conditions of high stress, males who committed suicide were perceived less negatively than females. The writer concluded that "an adequate explanation of the variance in the negativity of expressed attitudes toward suicide would necessarily include both respondent and suicide-related variables and the interaction of these variables" (p. 5236B).

In summary, this section has pointed out that the public in general seems to be fairly experienced with suicide and hold certain, generally negative, attitudes toward suicide and the suicidal person. In addition, several variables and the interplay between gatekeeper, suicidal person and setting variables appear to influence gatekeeper attitudes toward the suicidal person.

Training of Gatekeepers

In contrast to attitude studies (both of the general public and gatekeeper groups), little research has been activated showing successes of gatekeeper training. Although training has been urged, few studies have investigated how gatekeepers can be made more effective while incorporating what has been learned in studies of attitudes and factors affecting attitudes toward suicide.

The Report (1976) revealed that very little was being done in the province regarding training of gatekeeper groups. In an agency survey, it was concluded that "very few have staff with significant training in dealing with these problems [of suicide] and little information is being disseminated to those who are in a position to apply it" (p. 47). Throughout the Report emphasis was placed on the need for such training.

This concern for training is reflected again and again in the literature. A Task Force in the United States (Maris, 1973) made similar recommendations for training of gatekeepers. These recommendations are echoed by Shneidman (1970b) and the WHO (1968).

More recently, specific groups have been urged to devise specialized training programs for their trainees. Kelly (1973) investigated the training of psychiatric residents as a result of a concern over the suicide rate of that particular group. His research study found that only "half of the respondents [psychiatric resident program directors] showed a positive interest in assisting residents in personal growth and emotional maturation as part of their professional training" (p. 466). Kelly gave suggestions on how to most beneficially include training for the encountering of suicidal people by the psychiatric residents. Shein (1976) enumerated obstacles in the training of psychiatric residents in suicide intervention. The author listed personal and professional anxieties and misinformation as obstacles on the road to adequate training, then suggested ways to overcome the problems. Danto (1976) dealt with a related group—psychiatric suicidologists and gave specific suggestions for their training and supervision. Allen (1976) addressed himself to training health educators for their role in suicide prevention. A study of clergymen and disc-jockeys by Berman (Note 2) "highlight[ed] the perceived appropriateness and need of working with and providing training to a variety of indigenous professional and non professional gatekeeepers" (p. 4). Steele (1975), investigating the training of medical students, discerned a special reticence in the students to perceive suicidal intentions even after a special lecture. He concluded:

> Until we develop effective means for helping students recognize and tolerate thinking about such highly charged topics as . . . suicide, students will not, despite their high intellectual abilities, be able to cope with some of the most profound aspects of their patients' distress. (p. 205)

The need having been established, many people have gone to create special training programs in suicide intervention. In Edmonton, the Distress Line, a telephone crisis service, devotes part of its training manual to a brief overview of the special problem of suicidal callers (Distress Line, Note 3). After a survey of the incidence of suicide on national, provincial and city levels, the manual goes on to provide practical steps for volunteers. Many other "training manuals" exist as is pointed out in Resnik and Hathorne (1073) and Brockupp (1973). However, little effort has been made to organize and integrate all that is so far known.

Nevertheless, training programs continue to emerge, led by the

Los Angeles Suicide Prevention Center (LASPC, Farberow, 1969b; Heilig, 1970). Some actual courses in established training programs are in existence; one for medical students (Cohen, 1974) and one with a built-in evaluation for paraprofessional telephone volunteers (Thompson, 1974). As well, the Task Force in the United States (Resnik & Hathorne, 1973) has outlined a guide to future courses for gatekeepers. An important emphasis was given by T. L. Dorpat, a member of the Committee for Education and Training in Suicidology:

> Working with suicidal persons is an emotionally draining and frustrating experience. The high titre of anxiety and guilt engendered in others by suicidal persons is another reason for emphasizing the value of supervision and consultation. When either mental health professionals or gatekeepers are not helped to deal with their anxiety and guilt, they may manifest the suicidal antitherapeutic, defensive attitudes of retaliatory hostility and rejection. . . . Knowledge about how to relate to and treat suicidal persons is only gained by experience with them which is enlightened and supported by regular consultation. (p. 34)

In conclusion, as was seen in the first section of this chapter, a certain amount of knowledge now exists concerning public awareness of and experience with suicide. As well, the factors that influence gatekeeper interactions with suicidal clients have begun to be evaluated. However, training programs incorporating research results and the special needs of various gatekeeper groups seem to be almost nonexistant, certainly so in Alberta. Although some training programs now exist, few are being formulated with evaluation in mind.

Case Management of the Suicidal Client

Some research has been done in the areas of attitudes and training of gatekeepers as was outlined in previous sections of this chapter. A fair amount has also been written in connection with the actual involvement of gatekeepers with suicidal people. This literature can roughly be divided into three broad areas: recognition of the suicidal person (largely involving various oblique and obvious forms of communication), assessment (or evaluation of suicidal risk) and lastly, client/patient management (the intervention process). Much of the literature has to do with the processes and forces acting on the suicidal person; places where the interactional dynamics or the gatekeeper's role is mentioned will be specially noted.

Recognition

The first phase in working with a suicidal person is recognition that a suicidal crisis or way of life exists. An Interim Report (Solomon & Boldt, Note 1) to the Report of the Task Force (1976) gave figures for the pre-death communication of persons who had committed suicide in Alberta from 1968 to 1973. The actual making of a threat of suicide ranged from 3.8% to 37.2% of various age and sex groups of people who committed suicide; moreover, an atypical pre-death behavior (oblique suicidal communication) was reported in from 78% to 92% of the cases. Much earlier, Shneidman and Farberow (1957) suggested, in studying suicide notes, that "calling upon professional psychiatric, psychological, and social work specialists for the treatment of a potentially suicidal person may mean the difference between life and death" (p. 9). In 1968 WHO reiterated that warnings given by suicidal people should be acted upon. In addition, Pretzel (1972), in a major book, emphasized the communicative aspect of suicide.

However, difficulties are encountered in attempting to delineate what is suicidal (death-intentioned) and what is not. Various authors have stressed that the phrase "attempted suicide" should be replaced by a more suitable term, since many suicidal behaviors are more communicative than lethal in intent. Freeman, Wilson, Thigpen, and McGee (1974); Kessel (1966); and McCulloch and Phillip (1967) have all concluded from research that suicide has many motivations. Most recently, Morris, Kovacs, Beck, and Wolffe (1974) have argued that "the notion that suicidal intentions are an all-or-nothing response is not supported by our data" (p. 545). Many authors have investigated various elements of suicidal communication. Snyder (1971), quoting from the American Joint Commission Report on Mental Illness and Health, found that of people with emotional problems 42% turned, in the first instance, to a clergyman for help; 22% to a family physician, and 39% in the lower socio-economic group did not know who to turn to. Studies that have specifically focused on suicide have again and again reported high rates of communication prior to committing suicide. Sainsbury (1972) reported that 50% of the individuals who had committed suicide had visited their doctor in the week before their suicide and 20% had been under psychiatric care. The author gave conclusions that have been supported repeatedly, "Clearly the community services are failing to recognize the suicidal" (p. 196).

Stengel (1968, 1973) provided evidence that suicide was a social, other people-directed communication; suicide often occurred with other people nearby. In two major reviews of suicidal communication, Lester (1972) and Murphy and Robins (1968) found that the usual figure quoted is 2/3 of all suicidal peole communicate their intent to those around them, to those that would care to listen.

The problem of suicidal people is often to get someone to listen and respond. Litman (1970a), states, "The tragedy is that the suicidal communication is perceived but conscious recognition of its significance is avoided, denied and repressed" (p. 442). Two other studies outline the difficulties in the perception of suicidal communication. Cowgell (1974) and Giddens (1971) point out that anxiety, fear and an immobilization response are usually aroused in the audience.

Hatton, et al. (1977) have noted that the symptomatic trappings of suicide are also a form of communication of acute distress:

> Most important, since it is so often apparent to others, depression can be viewed as communication of a self-inflicted state of deprivation. Thus, at the same time that depression serves to protect the subject from more pain than that already being felt, it has an outward movement as communication to the environment which can be viewed as an attempt of sorts to effect change. (p. 24)

More recently, it has been shown that suicide is often a progression of life events that culminates in a suicide attempt or a suicide. Humphrey, French, Niswander, and Casey (1974) have demonstrated that there are specific patterns of events leading up to suicidal behavior, mostly social in nature. This research has been echoed by Paykel, Prusoff, and Myers (1975) and Sendbuehler (1973). Many of these pre-suicide events can be seen as a gradual exhaustion of resources, and potentially as an ideal place for active intervention, as opposed to awaiting a more desparate "cry for help."

In summary, suicidal communications, difficult as they may be to recognize, need to be preceived by gatekeepers. Although a suicidal act may be motivated by a variety of factors, clues are almost invariably given that can lead to intervention. This section on recognition of suicidal people emphasizes the need to lessen one's resistance to the perception of a suicidal communication.

Assessment

Once a gatekeeper has decided to respond to a suicidal communication, some sort of evaluation is needed. Perhaps the greatest bulk of research in the area of suicide intervention is devoted to finding or developing instruments that will help predict the level of suicidal risk.

However, as many have pointed out, assessment is not an easy task. As Neuringer (1974b) says in a major review on the problems of assessment, "The chief problem hindering the development of valid data to be used in making suicidal assessments is due to a lack of knowledge about the psychodynamics of suicide" (p. 4). Beck, Resnik, and Lettieri (1974) in a work entitled The Prediction of Suicide and Resnik and Hathorne (1973), in their review of the status of current research, concur with Neuringer. Good work exists in the field but it is not accurate enough for individual prediction.

As well, there are many methodological problems plaguing the area of valid prediction of suicidal behavior. In a review of the literature, Brown and Sheran (1972) conclude that there exist no real instruments (including single signs, standard psychological tests, especially devised tests, clinical judgments, and scales) to accurately predict suicide. The WHO (1968) further explained the problem by stating that although factors exist that predict in large-scale studies, a transfer of the methods cannot be made with any degree of accuracy to the individual case. Freeman, et al. (1974) agree from their research findings that "enough exceptions exist in nearly every demographic combination to caution against generalizing to a single individual" (p. 35).

The problems with assessment make the task of the gatekeeper in evaluation of a suicidal client difficult at best. Notwithstanding these problems, some generally agreed-upon schedules of aids to suicide prediction exist. Litman and Farberow (1970) and the LASPC have led the field in the development of such instruments. Certain combinations of demographic data (such as age, sex and onset of self-destructive behavior), clinical characteristics (short or long term crisis and resources), and evaluative clinical judgments (such as the quality of communication and the personality status of the client) have to be taken into account. The clearest and most practical elaboration of this occurs in a recent work (Hatton, et al., 1977). Interestingly enough, after outlining many factors to be considered, Hatton, et al. state that the gatekeeper should rely in the final analysis on intuition, since the "caregiver may be attending to certain nonverbal cues or some feeling tone which suggests that the cry for help has been muffled by some interference as yet unidentified, which is actually stifling a piercing scream" (p. 57).

Other writers in the area have taken different slants on what needs to be considered in assessment. Pokorny (1974) believed that the suicidal person should be rated on his/her lethality, intent (degree of sincerity about taking his/her life) and method of proposed injury; the mitigating circumstances should be taken into account as should the certainty of the observer/gatekeeper. Kiev (1974) followed up 300 suicide attempters and found prognostic signs for three variables: interpersonal conflict, symptom distress and social setting of the attempt.

The complexity of assessment has been emphasized by other authors. McCulloch and Philip (1967) found many social factors that were important in a suicide attempt. Murphy and Robins (1968) reviewed which psychiatric symptoms were predictive of various forms of suicidal behavior. And lastly, Shneidman and Farberow (1970) attempted to differentiate characteristics of completed suicides and attempted suicides.

As many reviewers have pointed out, much remains to be done. In addition, changing patterns of suicide are making the task of adequate prediction even more complicated ("Study reveals drop," 1976). However, for the practicing gatekeeper some guides do exist that will help in the evaluation of client suicidal intent.

Intervention

Once the gatekeeper has responded to the suicidal communication and is reasonably sure some risk is present, various management techniques based on others' previous experiences are available. Although intervention procedures are suggested, present theory falls short of serving as an adequate guide for intervention. The most common method of management given is a form of crisis intervention, based again on its original successes in the LASPC. In addition various other proposals are set forward that may aid in intervention. Literature also exists which covers intervention with special risk groups, such as the chronically suicidal.

Theories of Suicide

Theories related to the management of suicidal clients can, in large part, be classified as: psychological, social or psychosocial. However, such classifications are not mutually exclusive, since suicide is a complex process and contains elements of many types of dynamics. In Litman's (1968b) review of Freud's beliefs about suicide, he concluded that Freud believed that certain general features of the human condition made each person vulnerable to suicide to some degree, specifically the death instinct (inward- and outward-directed aggression) and the splitting of the ego. But Litman concludes the article by stating:

> In such emergencies [at the LASPC] of course, we work, not from theory, but with intuition and judgment, seeking words, gestures, or actions that will relieve tension and establish communication. The key might be an understanding look, a shared feeling, or a cup of coffee. (p. 23)

Psychological theories were best presented in Farberow and Shneidman's pioneering work, The Cry for Help (1961). Few of the theoriests offer practical or even usable suggestions. Farberow (Note 4) outlines the psychological aspects of suicide clearly, again with few indications for case management. The behavior therapists, just recently upon the scene, have begun to attempt some management of suicidal behavior employing operant conditioning (Bostock & Williams, 1974; Spector, Note 5).

Sociologists also have theories of why suicidal behavior occurs. Major reviews of these theories exist (Lester & Lester, 1971; Maris, 1975). Collective behavior and suicide rates are examined; little can be extrapolated to the individual case.

A significant sub-type of theory exists, which can best be described as psycho-social, although Leonard (1967) uses the word "developmental." According to this theory, based on experiences in the ages 2 to 3, inadequate resolution of the individuation struggle occurs. This leads to three basic suicidal types: the dependent dissatisfied, the satisfied symbiotic, and the unaccepting. Tabachnick (1961) and Litman (1970d) focus on what Leonard has called the satisfied symbiotic type, exploring the need and the dependent sadomasochistic features of such a relationship. Diekstra (1972), while not commenting directly on any of the suicidal types given by Leonard, affirms that the social expectations and reactions of others influence the suicidal person's behavior. Adler, in particular, as reviewed by Ansbacher (1969) and Messer (1973), views the social contexts of suicide. Therapeutic suggestions are offered but are inadequate to cover all instances of suicide.

More recent theoretical formulators have attempted to theorize with more practical prevention and intervention implications in mind. McCulloch (1972), in particular sees three groups of suicidal behavior: 1) a rational act, 2) an act brought on by mental illness or, 3) a result of psycho-social difficulties. He advocates an active intervention with a matching of patient and therapist based on principles not yet known.

Crisis Intervention

While theories of suicide have offered clues to the diverse motivations of suicide, crisis intervention theory has put forward the most practical basis for actual management of suicidal clients. Most succinctly, the theory (Aguilera & Messick, 1974) states:

> Between the perceived effects of a stressful situation and the resolution of the problem are three recognized balancing factors that may determine the state of equilibrium . . . . These are perception of the event, available situational supports, and coping mechanisms. (p. 54)

The minimum goal established by crisis therapists is the psychological resolution of the present crisis and restoration to a level of functioning that existed before the crisis. This is a goal-oriented intervention. The steps are, briefly: assessment of the problem (focusing all the while); planning an intervention; carrying out the intervention (involving helping the client gain an intellectual understanding of the problem, helping the client explore his feelings, an exploration of the client's coping mechanisms and a re-opening of the client's social world); and a resolution of the crisis and anticipatory planning.

Various writers have adapted the crisis intervention model to suicide intervention. McLean (1969) has outlined the phases of an interaction: 1) establish a relationship, maintaining contact and obtaining information, 2) identification and clarification of the problem, 3) evaluation of suicidal potential, 4) assessment of strengths and resources, 5) formulation of a therapeutic plan, and mobilization of the patient's and others' resources (p. 34). Hatton, et al. (1977) and Pretzel (1972) further elaborate on these steps in two books on the subject of suicide intervention. The effect of crisis on an individual, as Schulberg (1974) points out, has unique features. Crisis is time-limited, is marked by radical changes in behavior, is subjectively experienced by hopelessness, ineffectiveness and tension, and the perception of threat is unique to each person.

Farberow (1967, 1972b) sees suicide therapy and crisis intervention as different. For him there are unique aspects to a suicidal crisis including a person's feelings about death, his communication of intent and his ambivalence about the event. According to Farberow, the treatment involves activity, authority and involvement of others. The effects on the therapist are different too; there should be frequent consultation in the case of suicide intervention.

McClean (1972) further elaborates potential effects on the therapist:

> When a mental health worker is anxious, his behavior may parallel the client's in rigidity in thinking, selective inattention, distortion, and other typical anxiety effects. . . . The communicated message is often that the worker is as overwhelmed by the client's problems as is the client. (p. 176)

The preferred method of intervention suggested so far to the gatekeeper has been a model of crisis intervention. As Snyder (1971) has emphasized, "The basic commitment is toward making those channels of help that exist more effective, rather than attempting to superimpose on the community artificial channels of help that come out of our own attempts at social engineering" (p. 39). Snyder's plea is for keeping suicide intervention in the community, which should be given the methods to deal with crises. Within this community, gatekeepers may need specialized knowledge in order to help certain groups.

Intervention with Special Groups

Adolescents. One of the fastest growing problems is the marked rise in adolescent suicides and attempts. Bagley (1975) has pointed out the increase in completed adolescent suicides as have local reports ("Youth suicide rate," 1979; Solomon & Boldt, Note 1). The dramatic rise in attempts has been chronicled by Weissman (1974); Weissman, Paykel, French, Mark, Fox, and Prusoff (1973) and in Canada by Ramsay (Note 6). Weissman et al. (1973), in a concluding note, state:

> This trend could be summarized as a marked rise in suicide attempts over the past 10 to 15 years, mostly in young people. The attempters are usually under 30, twice as often women than men. The attempts are mostly impulsive acts, with little intent to kill oneself and the method used usually is ingestion of pills. (p. 90)

Peck (1977) has attempted to identify the feeling state of the adolescent prior to suicidal behavior. The result, people feeling more isolated and hopeless and less optimistic, is much the same as that for adults. However, various authors have mentioned what Peck has in regards to the familial background of the adolescent. Parents of families with suicidal youngsters frequently strive hard for success and expect their children to do the same. This pressure on the adolescent to succeed is matched by an inadequate channel of communication to the parents for their denied negative feelings (Bagley, 1975; Hendin, 1975; Rabkin, 1978; Peck & Seiden Note 7). Bagley (1975) added factors of early trauma, current family and soical disorganization, the onset of puberty and the moral climate of our times to the list of motivations for youth suicide.

As in intervention with adults, the first step in helping youngsters is recognition of a problem. Finch and Poznanski (1971) and Otto (1972) suggest that although the signs are essentially the same, the depression that often accompanies suicidal behavior may be more difficult to recognize in adolescents. This depression can be concealed by seeming nonchalance, indifference or provactive behavior. Evaluation or assessment of the suicidal risk follows much the same pattern as that for adults (Finch & Poznanki, 1971; Ramsay, Note 6; Peck & Seiden, Note 7). Managing the crisis, however, involves greater emphasis on the role of the family (Finch & Poznansik, 1971; Otto, 1972; Ramsay, Note 6). As Weissman (1974) points out, dealing with the problem of adolescent suicide today may decrease the suicide rate in the upcoming years, as the present attempters age and perhaps again attempt suicide as a means of communication.

The Elderly. A few other special groups have been briefly mentioned. Wolff (1970), in dealing with the elderly, has established certain goals for therapeutic managment that are somewhat different than those for other adults. He says, "To convey hope, re-establish confidence, and overcome undue fear of death have to be our therapeutic goals"

(p. 42).

Children. Child suicide has only recently begun to be researched. Hatton, et al., (1977) have theorized that the role of the family is even more crucial in child suicide than in adolescent suicide. The child may use suicide as a means of acting out the hurt and pain of the entire family. Assessment needs are complex, the development of the individual child must be viewed against a background of the norms for the child's age group. As well, there must be an understanding of the child's view of his own behavior. Unique therapeutic aids of art and play are suggested as beneficial.

Chronically suicidal. A very special need, certainly not adequately covered in the literature, is a need for development of therapy techniques for a group of people who do not fit into the neat category of being in a state of "crisis." These are people, who as Hatton, et al. (1977) point out, "present a life style of suicide" (p. 85). Farberow (1968a, 1972b) attempted to distinguish sub-groups among such chronically suicidal people. He saw three groups: an unstable down-and-out group, characterized by alcohol and drug abuse and poor physical health; a chaotic group, characterized by a continuous pattern of agitation and psychotic and disorganized behavior (relatively independent of stress); and a group of "malignant masochists." Ovenstone and Kreitman (1974) attempted to experimentally establish two types of suicidal people from a sample of people who actually completed the act of suicide; again the distinction is between a stable group, with suicide precipitated by an acute crisis, and a chronically disorganized group, mainly alcoholics. The preceding behavior that distinguished these two groups was previous attempts—those who were chronic had more likely made a suicide attempt before the completed suicide. Bagley, Jacobson, and Rehin (1976) have attempted to experimentally distinguish three types of completed suicides: a chronically depressed, a sociopathic (notable by a "cycle of deprivation") and a physical illness group.

Other authors have tried to distinguish two groups: the acutely suicidal and the suicidal personality (chronic). Schwartz, Flinn, and Slawson (1974) suggest that crisis intervention techniques will not work with the second group. Farberow (1972b), in work with the LASPC, had attempted to promote a program of "continuing relationship maintenance therapy." In relation to this, Wold and Litman (1973) offered research which showed that the people who had called the LASPC and had subsequently suicided were suicides "associated more with gradual exhaustion of resources than with sudden loss or stress" (p. 735). As a result of the urgings of Farberow and the research of Wold and Litman an eighteen month outreach program was begun by the LASPC. A rehabilitation model stressing client strengths was attempted. In comparing suicide rates (Wold & Litman, 1977) of the befriended group and a comparable non-befriended group, the authors concluded that the program was a failure. There were no differences in the suicide rates of the treated and untreated groups. All but one of the people in the program of rehabilitation who committed suicide were alcholics. As well, the program failed in other respects:

> Volunteers were unable to sustain their own enthusiasm and optimism when confronted by the pessimism, sharp mood changes, orientation to failure, and dissatisfied dependency of these suicidal alcoholics, for whom maintenance of a relationship on a 'once a week, we call you' basis was insufficient. (pp. 180-181)

In conclusion then, there is increasing evidence that management of (a) certain type(s) of suicidal sub-group(s) is very difficult. This deduction is further supported by Ettlinger (1975) and Motto (1972) who both studied groups which were subjected to further therapy after an attempt. No differences between "treated" and "untreated" groups were seen. Motto extrapolated from the findings that management lagged behind recognition. An area worthy of further investigation was alluded to by Brown and Sheran (1972) as they stated, "Suicide prediction may be markedly improved by determining the signs that indicate high risk for each subgroup rather than for all suicidal persons" (p. 88).

Gatekeeper Groups

Crisis Center Workers

Some research has been done for and by community crisis centers. Once community organizations are established, an attempt is sometimes made to review their status in the community, documenting who in the community may use these centers. As the center is being established, volunteers are quite often invited to join in the personnel of such a center. Various descriptions of what is offered as training for these volunteers exist. More recently, two aspects of volunteer involvement have been studied. The first looks at the personal characteristics of volunteers, attempting to assess their personality as it may affect their performance. The second aspect of volunteer performance studied, examines why a worker is effective and involves developing instruments or techniques for gauging such effectiveness.

Nationally, for the United States, a much needed kick-off to further development of community centers was given by the National Institute for Mental Health Center for Studies of Suicide Prevention's 10 point program (Shneidman, 1967). For each community the organizational need and problems are unique. Chen (1969) in a description of the Flint, Michigan, experience wrote of the problem of finding the right agency to begin crisis services. Such an agency in this particular community, needed immedicate access, 24 hour service and non-association with the police or local psychiatric services. Staffing was largely volunteer. In contrast Hoxworth and Toole (1970) in Adams County, Illinois, described an organization staffed entirely by professionals. Usually these community agencies deal with a wide variety of calls utilizing, depending on the agency, telephone and/or personal contact. Normally suicide calls average around 10% of the total activity of such a center (Tarrant, 1970; Thomson, 1968). Since each community has specialized needs and already existing patterns of interaction, specialized services develop. In Cleveland, Sudak, Hall, and Sawyer (1970) found that a coordinating facility for emergency psychiatric care was needed; Greaves (1973), in Kitchener-Waterloo, staffed a facility in an already existing outpatient psychiatric department. In more recent innovations Ruiz, Vazquez, and Vazquez (1973) described a mobile Crisis Unit in a New York ghetto. Volunteers are drawn from the community-at-risk and the authors acknowledge "the effectiveness of nonprofessionals must be emphasized since much of the strength and knowledge in problem solving comes from this part of the staff" (p. 24). In a unique over-proliferation of services, Hurley and George (1974) confess that in St. Louis, Missouri, perhaps a pooling of existing information and services should take place, a combinative effort of the area's present 22 agencies.

Some agencies, once established, try to determine their impact on the community. Ginsburg (1971a) found that although 76% of a sample population of Reno, Nevada knew someone who had attempted suicide, only 26% knew of the local crisis center and of this 26% most would not use the agency. In New Orleans in a similar study, results were more encouraging (Swanson & Breed, 1972). Only 27.5% of the sample replied that they would never use a local suicide prevention center. The people who would use the center expected a variety of services: rescue, redefinition of the existing crisis and friendly, emotional support. Nelson (1972) surveyed community agencies' views of the Nashville, Tennessee Center. The center was seen as highly active and a source for referrals rather than as a telephone counselling center. Unhappily, most large-scale recent studies have found no difference in suicide rates between cities with suicide prevention centers and those without (Lester, 1974).

However, such centers still exist, indeed are proliferating at a great rate; see Fisher (173) and McGee (1974) for two volumes that outline the services of present centers. Very often, in such community crisis centers or suicide prevention centers, the services of volunteers are used. Various authors have outlined procedures that could be used or were used with volunteers in various organization for crisis or suicide intervention. One of the first centers in the United States to utilize non-professional volunteers was the LASPC. This program on the selection, training and use of these first volunteers in suicide prevention has been outlined by Heilig, Farberow, Litman, and Shneidman (1968); Farberow, Heilig, and Litman (1970); and Pretzel (1970). The procedure for selection and training has been previously described in this chapter in the section relating to intervention with the suicidal client. This crisis intervention approach (McGee, 1974; Roberts, 1975), consists of an initial establishment of contact, an evaluation, and a decision as to a course of action. Other authors have specified: the problems involved in what is usually telephone counselling (Lamb, 1969); new developments in the theory of suicide that may affect crisis interveners (Draper & Margolis, 1976) and novel uses of volunteers (Termansen & Bywater, 1975).

Various studies have outlined the crisis intervention worker more specifically and his role vis-a-vis the interaction with the suicidal client. Several authors have expressed concern that the work of crisis intervention attracts volunteers that are similar to the population that they serve. McClure, Wetzel, Flanagan, McCabe, and Murphy (1972), involved in a psychiatric study of suicide prevention center volunteers, confirmed earlier research which indicated that "a suicide prevention-crisis-intervention center does attract a large number of would-be volunteers who have had a psychiatric illness" (p. 327). The authors argue for an initial psychiatric screening of all applicants. However, Tucker and Cantor (1975) found that actual working volunteers, while resembling suicide attempters in a personality profile, thought about suicide infrequently and unlike attempters had a more stable family background and demonstrated more adaptive modes on behavioral items.

Further on this line of research, Ansel (1973) was among the first to begin to develop techniques and instruments for assessing volunteer effectiveness. Ansel looked at personality, personal history and demographic variables of volunteer performance. No significant results were found in a multivariate analysis. Belanger (1973) designed a clinical effectiveness scale using items from the California Psychological Inventory. In another approach Slaikeu (1974) and Slaikeu, Tulkin, and Speer (1975) tried to find out what in an interaction between a caller and listener got callers to come in for a face to face session. Even though the results of the study showed that caller motivation was the key to the decision whether to come in or not, the beginnings of research in the area of the worker-client interaction process had been made. Recently, Powell, Heaton, and Ashton (1974) and a center in Florida (described by Shneidman, 1976) have developed more precise instruments for gauging telephone interaction. Various conclusions were drawn, reflecting on the worker-client interaction as a dynamic process:

> Once we know, in behavioral terms, what has worked best, we will be in a position to describe optimal worker behavior in concrete, behavioral terms. (Powell, et al., 1974, p. 239)

> It seems that there is evidence of dynamic links between the personal behaviors of the crisis worker and what happens to the caller as a result of his interaction. (Shneidman, 1976, p. 491)

In conclusion, volunteers used in local centers face problems unique to their communities. However, crisis center workers and especially telephone workers appear to have a number of practical courses outlined for them. In addition, evaluation guidelines of volunteer performance vis-a-vis the suicidal client could conceivably be developed by other gatekeeper groups.

Medical Personnel (Specialized Cases)

A gatekeeper group that is hard to define yet relatively simple to identify works within various institutional settings and as such is influenced by these situational contexts. Within gatekeeper suicide research, the two most frequently mentioned settings for interactions with suicidal people are emergency wards and hospitals.

The first disposition of a suicide attempter or often someone contemplating suicide is the nearest emergency ward of a hospital. As authors have pointed out this can be a very beneficial contact for the suicidal person. At this choice point the patient is frequently vulnerable to presentation of alternative behaviors. Help is required for the body, the mind and the emotions (Monto, Ross, Heymann, & Rosenthal, 1975; Rabkin, 1978). As Gershman (1969) has indicated, "His [the suicidal patient's] period of readiness [for help] can be just as short in time as it took to enact the cry for help" (p. 95).

The attitude of the staff to the suicidal patient is critical at this point. A previous section, on attitudes toward suicide, has outlined the generally negative attitudes of the general public and gatekeepers toward suicidal people. Again, Welu (1972) indicated that of the medical staff in an emergency room (excluding nurses), only 10% were positive in their attitudes; 60% were indifferent or subtly negative and 30% were outspokenly hostile. Nurses however, were more positive as a group with 50% being positive and 40% indifferent (mostly ambivalent and/or anxious). Syer (1975) supports Welu's research in a description of a typical emergency ward scene:

> To have the death-anxious doctor confronted by a death-seeking patient is to invite a certain strong emotional response on the part of the former directed against the latter. This response is frequently a self-righteous anger. (p. 34)

Normally the actual treatment in an emergency room aside from the clearly medical choices, is centered around psychiatric assessment and management. Advice for these clinicians is given in various emergency psychiatric treatment manuals (Harris & Myers, 1968; Lieb, Litpsitch, & Slaby, 1973; Myerson, Glick, & Kiev, 1975; Slaby, Lieb, & Tancredi, 1975). The best, clearest and most practical presentation of material, in this reveiwer's view, is in Myerson, et al. (1976). The authors review assessment (focusing on lethality, intentionality and patient attitude), treatment approaches, establishment of guidelines for disposition of the patient, medication and follow-up procedures.

While sources for the discussion of ideal evaluation and case management are represented in the preceding paragraph, actual research has occurred, focusing on various factors affecting treatment and disposition. Treatment has often been affected by patient attitudes toward the help given. Weisz, Staight, Houts, and Voten (1968) found that the "suicide attempters presented special problems for the emergency psychiatrist because of their lack of cooperativeness, lack of symptoms, and the feeling of 'no help given' which they projected to the therapist" (p. 238). The authors suggest improved training could better prepare hospital residents for patient hostility and resistance. Paykel, Hallowell, Dressler, Shapiro, and Weissman (1974) investigated treatment patterns for suicide attempters and determined that clinical criteria reflecting severity of the attempt and risk of repetition influenced hospitalization more than attitudinal and social factors. However, in the same study, the clinicians had the most negative feelings about chronic attempters with a psychotic symptom pattern and these patients were most likely sent to a state hospital. In a similar finding of the influence of negative feelings in psychiatrists, Kirstein, Weissman, and Prusoff (1975) concluded that "the clinicians' intense unsettling feelings may contribute to an underestimation of the patients' depth of depression, thereby accounting for nonhospitalization" (p. 55).

In contrast to traditional emergency ward procedures which may not utilize the services of a psychiatrist, a program in the Toronto East General Hospital is described by Rabkin (1978) and Syer (1975). The purpose of this crisis unit is to befriend, assess and counsel both the suicide attempter and his family at the time of the attempter's presentation at the hospital emergency ward. Although few statistics exist for the program, after two and a half years only four clients out of 1,000 had subsequently committed suicide.

The most depressing statistics that exist in the area of research on emergency wards are the studies that focus on follow-up of the suicide attempter. As Boldt and Solomon (Note 8, p. 74) indicate for Alberta (1968 to 1973), persons committing suicide, aged 30 to 59, have previously attempted suicide in over a third of the cases; 30% of youths, aged 15 to 29, who finally commit suicide, have previously attempted suicide (Solomon & Boldt, Note 1, p. 71). Bogard (1970) found that 64% of a sample population of suicide attempters went home after emergency medical treatment without previously arranging for further treatment. Similar findings were reported by Paykel, et al. (1974); only one half of a sample of outpatient referrals showed up for their first appointment. Similarly Goldney (1972) reported figures of 46% failing to come to an outpatient clinic. As well, Monto et al. (1975) disclosed that five out of ten hospitals in the Bay Area of California discharge suicidal patients without psychiatric consultation of any kind. Weissman, Fox, and Klerman (1973), in a study of suicide attempters, emphasized:

> Given their high potential for successful suicide and their tendency to underrepresent their depression and to alienate staff and family, maximum efforts to treat and follow the suicide attempters should be made. (p. 454)

That psychiatric treatment after release from emergency can have some positive effects is supported by the research done by Greer and Bagley (1971) and Bagley and Greer (1974). They reported that psychiatric intervention was associated with a significant reduction in subsequent suicidal behavior.

In a lucid article on the medical sociology of suicide, Vlasak (1975) explored the incongruencies between the traditional "sick" role and the aspect that a typical suicide attempter presents. The exemptions, rights and obligations inherent in a normal sick role are inconsistent with suicidal behavior. Such incongruency tinges any social interaction (between patient and emergency staff or hospital staff) with tension and instability. Within a suicidal context victim and cause are the same, whereas in normal illness the cause is usually seen as extraneous to the patient.

One of the possible despositions of the suicidal person in the emergency ward is hospitalization. However, in some centers, as Monto, et al. (1975) point out, certain gaps are evident in hospital services. Eligibility to enter a hospital may interfere with or discourage the offering of services, assessment may be done by someone lacking special training, and referral information is often not communicated to others in the institutional setting.

Several articles concerning hospital treatment of the suicidal patient are merely statements of recommended practice, with no basis in research (Harris & Myers, 1968; Macfie, 1965; Russel, 1975; Stengel, 1968). All emphasize the importance of staff attitude toward the suicidal person. As well, the authors stress the necessity of interstaff communication, a definite treatment plan, education and follow-up. The best article of this type, that this writer could find, utilizing the most recent knowledge in the field and given in practical steps for beginning psychiatrists, is Beebe's (1975). He recognizes at the conclusion of his article that:

> In all fairness, it must be recognized that the closed world of suicide can produce contagious exhaustion. Endless ambivalence, vengeful dependency, repetitive pressure for reassurance, and frustrating denial wear out those who want to help. Passive negativism is so exasperating that it regularly elicits lecturing and negativism. (p. 39)

There has been some exploration of the influence of the hospital setting on gatekeepers' interactions with the suicidal person. Snavely (1969) found that more extensive clinical experience tended to make one more conservative in his/her (psychiatrists, nurses, nursing assistants) judgment and subsequent treatment of potentially suicidal patients. The author concluded that factors which relied on experience and institutional norms were determinants of clinicians' decisions about suicidal potential.

As in research on follow-up from the emergency ward, follow-up after hospital release appears to be indicated. Rettersol (1974) followed suicide attempters as they left hospitals and psychiatric clinics. Suicide rates for patients released from hsopitals were two to three times higher than rates of suicide for patients released from clinics. A higher rate of psychosis in hospitals appears to account for this heightened suicide rate. The necessity of follow-up after hospital release is further supported by Farberow, Ganzler, Cutter, and Reynolds (1971).

The patient's inner experience of depression in hospitals was uniquely examined by Reynolds and Farberow (1973). From an actual hospital experience, to which a clinical psychologist and clinical anthropologist deliberately exposed themselves, the authors concluded:

> The thrust, however, is that overtly or covertly we convey to others what we think they are worth. . . . To the person who is debating within himself whether he is worth keeping alive, this message of concerned human support is the most important message we can send. (p. 269)

This message was echoed by a study on a specific sub-group, of cardio-respiratory patients who committed suicide (Farberow, McKilligott, & Darbonne, 1970). These writers closed with the observation that "the most important antisuicide measures remain the sensitivity and alertness of the staff to the suicidal danger and the indication of interest and concern for the patient as a person" (p. 384).

The greatest concern in research about gatekeepers in hospitals centers around hospital suicides. Individual cases and suicide 'epidemics' were reviewed in an attempt to prevent further such suicides (Anonymous, 1977; Farberow, et al. 1971; Harris & Myers, 1968; Kobler, 1964; Krieger, 1976; Pollack, 1957; Rotov, 1970; Richman, 1972). A combination of factors was usually found to be responsible: anxious, disturbed, sometimes secluded patients needing confirmation of the existence of hope side by side with uncertain, disorganized, non-goal-oriented staff with poor intercommunication. Often significant signs preceding the suicide were overlooked by the staff. This emphasizes again the need for a relationship between the staff and patient.

Certain themes emerged from the preceding section on and for specialized medical personnel. The most important stress is on the interaction between the suicidal patient and the gatekeeper. This section also noted that the treatment of the sucidal patient can be difficult. In addition more training in suicide intervention appears to be required by this gatekeeper group. The present staff in emergency rooms and hospitals in general need to be alerted to adequate treatment of attempters, proper follow-up procedures and the importance of gatekeeper attitudes and behavior toward a person contemplating or havint committed a suicidal act.

Psychotherapists

Whereas the previous section dealt with emergency and hospital treatment of suicidal patients, this section will examine psychotherapists in general as gatekeepers. Three aspects of psychotherapist-patient relationships will be viewed. The decision to intervene and its effects on therapists and clients is the first topic for discussion. Following will be a review of psychotherapeutic strategies regarding recognition, assessment and management of suicidal clients. The third section will chronicle the failures, the committed suicides while in psychotherpay.

In the general area of counselling the suicidal person, important orientating books exist in Pretzel's (1972) Understanding and Counseling the Suicidal Person and Kiev (1977) The Suicidal Patient. While of use to therapists, Pretzel's work is not so practically-oriented as Hatton, et al. (1977) and contains mostly general discussion. Kiev's work is directed mainly to psychiatrists and general practitioners and is more up to date than Pretzel's, yet less practical than Hatton et al. (1977). The best feature of Kiev's work is an outline of seven suicidal types, a typology based on research work on clinical outcome after an attempt.

In one of the early significant volumes on suicide, Farberow and Shneidman (1969), after discussing major theories and client management implications of the various theories, stated:

> The findings imply that a therapist who manifests sensitivity, warmth, interest, concern and consistency, within his own theoretical framework, may be of inestimable value to the suicidally troubled patient. (p. 320)

This conclusion on the positive effects of psychotherapy was supported by research done by Greer and Bagley (1971) and Bagley and Greer (1974). Treated and untreated groups of patients were followed up after admission to an emergency department. The results indicated that psychotherapy could indeed have a significant positive effect on subsequent suicidal behavior. However, therapists are often hesitant about taking suicidal clients. Hirsch and Dunsworth (1973) stated that in contrast to suicide prevention center workers, therapists saw greater numbers of more serious clients and felt more helpless in treating these clients. However, Reubin (1973) found that clinicians who agreed to work with suicidal clients saw therapeutic intervention as necessary and rewarding; therapists less willing to work with suicidal clients viewed such clients as requiring too much effort and expertise to compensate for the risk and consequences of failure.

Many recommendations exist for psychotherapists regarding recognition, assessment and therapy of suicidal clients. The best general presentation for psychotherapists appears to be Mintz (1968). This author sets a trend for emphasis on understanding and treating suicide, rather than theorizing. Subjects covered in this article include some orientation to suicide as an act with multitudinous motivations; detection and evaluation, and finally psychotherapy with an accent on the restoration of hope. Further, while Freudian in orientation, Mintz calls for an active intervention on the part of the therapist, believing that the therapist "must endeavor to present to the suicidal patient an attitude of patience, without indecisiveness; firmness, without rigidity; tolerance, without permissiveness; concern without perturbation" (p. 296). Most of the literature outlining therapeutic intervention with the suicidal client presents a Freudian interpretation of motives and eventual long term treatment. However, the most often-advocated treatment technique is a very active involvement by the therapist. Moss and Hamilton (1957) present the course of psychotherapy in three successive phases: acute, convalescent and recovery.

Other authors elaborate on various phases of treatment or present only a shortened form of Mintz's treatment procedure (Farberow, 1957, 1970; Litman, 1957, 1970d; Mayer, 1969; Wollersheim, 1974). The earliest and still the only offering of a number of theorists in a comparison study is Farberow and Shneidman (1961). Most studies are positive in nature; however, very rigid, negative views of suicide still exist as evidenced by De Rosis (1972) who in her advice to psychiatric residents says, "It is my opinion that with very few exceptions, suicide is a final act or culmination of intense, pervasive, hopeless self-hatred. . . . Furthermore, suicide is an act of psychosis" (p. 303).

The more modern trend in psychotherapy of suicidal clients tends to focus in on innovation specifics: specific types of therapy, specific techniques and specific groups, the bottom line being differential treatment depending on certain characteristics. Specific types of therapy showing promise are advocated by such writers as Paul (1970). He presents a strategy for allowing a suicidal "subself" to come into the person's awareness and battle with a caring "subself." Trexler (1973) employs a rational-emotive approach based on challenging the "nutty thinking" of the client and accepting our human fallibilities. Achte and Rechardt (1972) give an outline of brief psychotherapy to be used in crisis situations, "acting-out" and acute states of "psychic regression." The major stress of brief therapy is a concerned, caring clinician, an emphasis similar to that suggested in general techniques for case management.

Most recently, exploration has begun on chemical and biological correlates of suicide, with a view toward using chemical means to alleviate suicidal behavior (Snyder, 1975). Although in beginning stages, this research may add to knowledge of treatment techniques that can aid more long term "talk" therapy. In England and Wales, reductions in the rates of suicide in sections of the country employing a new approach, "community psychiatry", have been documented (Sainsbury, 1975). The key to such a new advance has been increased availability and accessibility of psychiatric services with lessening of patient apathy and withdrawal, traditionally seen in psychiatric wards and mental hospitals.

Techniques of therapy have been slow to be developed, based on as yet inaccurate knowledge of the motivations and "causes" of suicide. Kovacs, Beck, and Weissman (1975), after researching reasons for suicide attempts and levels of hopelessness and depression, postulated that eliciting the reasons for a suicidal act, understanding their implications, and finding out clincially how these implications affect therapy may be a valuable starting point for subsequent therapy. Even more specifically, Drye, Goulding, and Goulding (1973) present a system for assisting a clinician in making judgments of suicidal risk. Patients are asked to state how long and under what conditions they would be willing to stay alive. Exceptions to this technique would be addicted (alcohol or drug), organically impaired and some psychotic patients. Another technique, this time for confrontation of often-denied suicidal feelings after the act, is given by Resnik, Davison, Schulyer, and Christopher (1973). Denial of despair and an intentional suicidal act is challenged by a videotape of the patients' entry into the emergency ward of a hospital and the treatment they receive there, with emphasis on their emotions at the time as well as those of their families or "significant others."

Another parallel trend is for treatment strategies to be geared to specific groups. Beginning with Farberow and Shneidman (1957) differential treatment is given to various groups. These two authors suggest an approach based on age. Since younger clients, by research, were found to have more interpersonal motives and less chronic depression, a more dynamic psychotherapy is suggested. For older clients, environmental, milieu therapy is offered with support given to relieve feelings of discouragement, uselessness and being a burden.

Similarly Richman and Rosenbaum (1970), Rosenbaum and Richman (1970) and Speck (1968) encourage family therapy whenever possible, believing that "successful suicide . . . , is partly a result of his intimates' hostility and the victim's inability to retaliate" (Rosenbaum & Richman, 1970, p. 1652). Further, Speck (1968) sees the suicidal person's role in the family as expressive of a family system malfunction. Change will have to come within the family's communication system and in the family's communication system and in the family's communication with the outside world.

Sifneos (1970) has offered management techniques for clients he calls "manipulative." Sifneos sees special problems for the therapist since these patients often are unmotivated, hostile and unresponsive to suggestions. Bellack and Small (1965) present therapy procedures with depressed patients, following much the same advice as that presented for treating suicidal clients as a whole.

More recently and more comprehensively, Kiev (1975) has given a program for management of depressed and suicidal patients—a combination of chemotherapy and supportive, reality-oriented therapy in two phases: review of the symptoms, followed by changing and strengthening alternate ways of functioning. Stone and Shein (1968) and Shein and Stone (1969) describe psychotherapy of borderline and psychotic patients. Therapy proceeds from an initial crisis management to a management of symptoms to a characterological change. These authors believe that there is a shortage of material dealing with specific suicidal groups, "The data suggest that both within and without the hospital walls a major unresolved clinical problem is managing the known suicidal patient rather than simply detecting suicidal intent" (Stone & Shein, 1968, p. 15). Shneidman (1976) investigates treatment in a case of a destructive symbiotic relationship. The management of such a case focuses on increased self-reliance, strengthening of the ability to tolerate rejection and developing alternative methods of reducing tension. As Kiev (1975) has emphasized, "The techniques and the results of successful treatment vary with different psychiatric disorders. Personality factors influence the response to both psychotherapy and chemotherapy" (p. 353).

A treatment strategy offered increasingly as an alternative system and especially useful with chronic patients is group psychotherapy. Involvement and experimentation with this method of treatment was led by work at the LASPC. Farberow (1968b) related an approach that was structured as brief and crisis intervention oriented. The group became a source of support and renewed relationships for the participants. The therapists (and Farberow as well as others see the necessity of cotherapists) see an active, directive, involved role for themselves. Farberow (1972c) goes on to elaborate further extensions of group therapy in 1) an insight-oriented group, a more long-term approach and 2) a drop-in non-group. As Farberow put it, "What is needed is caring, concern and companionship. What better resource than a group for these three C's, the vital elements of suicide prevention?" (p. 242). The long term insight-oriented group attempted to focus on personality changes, with group members being characterized by frustrated dependency, inadequacy and high anxiety in interpersonal relationships. The drop-in non-group was seen as not yet ready for intimate relationships, yet in need of support. Lonely and depressed suicidal people were encouraged to form a loyalty to the LASPC rather than each other or to particular therapists.

Other types of group approaches have been advocated. Weisberg (1973) gave a description of an intensive group treatment of suicidal college students. This group was a high risk one composed of schizophrenics, depressive and psychotic members. The aims of the group were to avoid withdrawal and dissolution and to train members to make positive changes in their lifestyles. Billings, Rosen, Asimos, and Motto (1974) reported on similar groups for depressed and suicidal people. The group provided concern, interaction and interpersonal relationships. These long term groups focused on the gaining of insight into the individual members' problems and on learning how to express rage. Billings et al. (1974) often found that group members who remained with the group over a long period of time could, in effect, become co-counsellors, provoking other members in the aims of the group. Comstock and McDermott (1975) divided groups dealing with suicidal people into two: an introductory, short term group and a long term group dedicated to the goal of relinquishing maladaptive behavior patterns.

Psychotherapists are sometimes faced with the problem of completed suicide during the course of therapy. As Basescu (1965) reports, "The therapist's fear of suicide [after a completed suicide] is likely to result in overcautiousness. Consequently, the very qualities most needed, suffer, namely openness and availability" (p. 104). Bloom (1967) analyzed six cases of suicide occurring while the client was in psychotherapy, and reported that rejecting behavior by the therapist was evident in all of the cases. The author points out this countertransference problem can best be handled by consultation with colleagues and by the frank discussion (within therapy) of the clinician's hostile as well as positive feelings. Similarly, Litman (1965, 1968a, 1970e), in a discussion concerning 200 interviews with therapists whose clients had committed suicide, felt that supportive consultation was necessary after the event. The therapists reacted first as humans—shocked and dismayed by the event—and then as therapists, attempting to cope professionally with the event. A feeling of personal defeat and a period of hopelessness and depression often followed a patient's suicide. Denial and repression were frequently defense mechanisms used to suppress the suicide. As therapists, these clinicians were fearful of the consequences of the act for their professional standing, anticipating blame and inadequacy. Litman explained that "probably the best single indicator for evaluating high suicidal danger for the patient is the therapist's awareness of his own anxiety, which should not be denied or repressed" (1968a, p. 364). These findings by Litman are supported by a personal report of a failure by Perr (1968).

Stone (1971), while pointing out that no real systematic or comprehensive approach to suicidal patients exists, offered three types of "malignant" psychotherapies, which could aid in precipitating a suicide. Two of these poor practices involved undermining the ego defenses of the patient and one involed acceptance by the therapist and patient of the belief that the therapist is the only one able to gratify the patient. In the second instance the patient sees any moves by the therapist to move away from the patient as rejection. Bach (1974), using three personal experiences, gives evidence of the therapist's very real role in therapeutic failures. He describes three case reports of patient suicides, in which, contravening his own natural instincts, he continued to act as a "nice" therapist when what the patient needed was a tough, aggressive approach. Woods (1973) supported Litman's research in finding that therapists needed a time for their own mourning process after a patient commits suicide. He concludes that "medical training leads to an unrealistic image of the good, infallible and successful physician, while placing too little emphasis on the inevitability of apparent failure" (p. 70). This contention of Wood's is corroborated by Light (1976) in an excellent review of professional problems in dealing with suicidal patients. For Light, suicide is a double emergency for psychiatry; questions are raised about the therapist's competence and about the very nub of his profession—the power over life itself. Light advocates added research stressing training procedures and treatment procedures.

It is evident again from this section dealing with psychotherapists that intervention, difficult though it might be, can have a positive effect with a suicidal client. The importance of a warm, concerned, involved therapist was seen. Additionally, specific intervention techniques, such as group therapy, have been outlined that could be of benefit to other gatekeeper groups.

Doctors (Non-psychiatric)

Although hospitals, emergency and psychiatrists/therapists see many suicidal people, many people prefer to see their family doctor or a general practitioner when troubled by suicidal feelings. The literature on and for doctors includes articles containing research studies and those dealing with education or re-education of doctors.

Many studies have dealt with the fact that suicidal people see their own physician a short time before their suicidal behavior. The Report (1976) gave figures for suicides committed from 1968 to 1973 in Alberta, indicating that approximately 48% of the people who went on to commit suicide had seen a physician recently or were scheduled to do so (p. 272). This provincial figure is supported by other studies. Motto and Greene (1958) found that in 372 cases of suicidal behavior, 42% of the completed suicides and 59% of the suicide attempters had had recent medical contact. This data is repeated elsewhere. Murphy (1972): 82% of 122 completed suicides had seen a doctor; Sanborn, Niswander, and Casey (1970) in two studies: 72% had been to a doctor in the nine months preceding their deaths; Barraclough, Bunch, Nelson, and Sainsbury (1974): 2/3 of 100 cases of completed suicides had been to their doctor in the month before their final act; Hawton and Blackstock (1976): 62.5% of a group of suicide attempters had contacted their doctors beforehand. Even more alarmingly, patients often used the drugs prescribed by their doctors to make their fatal or non-fatal suicide attempt (Hawton & Blackstock, 1976; Motto & Greene, 1958). As well, clear indications of a depressive illness were sometimes overlooked, and incorrect treatment given, both as a result of the physician's poor training in mental illness and as a result of his inability to detect suicidal clues (Barraclough, et al., 1974; Murphy, 1969).

This reluctance to conduct a proper medical examination is often seen as a result of the anxiety engendered in the examining physician by the subject of suicide (Noyes, 1968; Motto & Greene, 1958; Sanborn, et al., 1970; Tabachnick, 1970). However, it is vital for this reticence to be overcome, since the most important part of any gatekeeper/doctor-patient interaction is the relationship established between the two (Friel & Frank, 1958; Lewis, 1968; Litman, 1966, 1970b; Sainsbury, 1975). As Tabachnick (1970) points out, in urging general practitioners to treat their patients, instead of referring them, "Experience indicates that the qualification of genuinely caring for another person is perhaps the single most important condition in treating suicidal patients" (p. 7).

To combat the physicians's lack of knowledge, many articles and a major work (Kiev, 1977) were written for physicians outlining clues to suicide, methods of evaluation and finally, broad management guides, frequently offered with recommendations for improved case handling

(Bennett, 1954; Friel & Frank, 1958; Lewis, 1968; Litman, 1966, 1970b; Sanborn et al., 1970).

Some authors chose instead to discuss only one or a few aspects of physician intervention with suicidal people: Sainsbury (1975) simply gives a few general recommendations for increased training; Shneidman (1970a) presents the clues to suicide; Tabachnick (1970) reports on two types of suicidal patients—interpersonal and intrapersonal and suggests appropriate management techniques; Arlen (1962) examines depression and its intimate relationship to suicide; Sanborn et al (1970) focus on the major reasons physicians fail to prevent suicide. These articles, while closely paralleling the information given to other gatekeeper groups, also accent particlar skills needed by the physician—when to hospitalize, mental problems masked by somatic complaints, psychiatric consultation and the careful prescription of drugs.

It can be seen that physicians can occupy a key gatekeeper role. The preceding section emphasizes the need for further training of doctors in recognizing, assessing and intervening with suicidal clients. Once again, the relationship between the gatekeeper and the suicidal person is noted as being crucial.

Nurses

Less literature is available for the following occupational groups—nurses, policemen and clergymen. Nevertheless, their contribution to the care of the suicidal person can be significant; their community functions need to be more fully investigated.

The nurse's role in intervening with suicidal patients has been presented within several contexts. Firstly, articles on general nursing care are available, similar to the general information available for doctors and other gatekeeper groups. These articles detail general knowledge about suicide that the nurse needs to have and further specifies guidelines for nurses in institutions. Closely connected to this information component are articles involving a discussion on the primary need in care of the suicidal patient—establishment of a relationship. Thirdly, suggestions are offered in articles for methods of greater involvement for nurses in suicide prevention and intervention in the community. Lastly, a special instance of increased nurse application to the process of suicide intervention in the form of home visits is chronicled.

Shneidman (1970a) describes some of the knowledge about suicide clues needed by nursing personnel. These include descriptions of verbal, behavioral, situational and syndromic indications of suicidal intent. Frederick (1973) gives further symptoms of suicidal intent. Westercamp (1975) presents the various sociological and psychological theories of suicide that exist, and goes on to discuss the special relevance of communication, the cry for help and ambivalence in suicidal patients.

The nurse's role is further specified in relations to her behavior on the general ward. Umscheid (1967) elaborates three primary therapeutic aims: protection, aiding the patient in constructively voicing his hostility, and helping the patient enhance and maintain a more realistic self-concept. Similar advice is offered by Leslie (1966) as she elaborates on the physical care of the patient: safety measures, observation, danger signals and occupational therapy. As well, nurses' notes are an important source of information for the therapeutic team, of which the nurse is an important part (Farberow & Palmer, 1964; Leslie, 1966).

However, as several authors point out:

> Through her communications, she can facilitate appreciation of the patient as a person rather than merely a collection of medical symptoms and thus contribute to the patient's feeling of being considered worthwhile. (Farberow & Palmer, 1964, p. 96)

This theme of the importance of establishing a relationship is repeated often throughout the literature dealing with the nurse and suicidal patients (Kessel, 1965; Leslie, 1966; Umscheid, 1967; Westercamp, 1976). As Kessel (1965) points out "don't just do something—stand there" (p. 961).

A vital aspect of the nurse-patient relationship is the importance of the nurse's awareness of her own feelings regarding suicide and the suicidal patient. This aspect of the nurse's role receives much emphasis (Kessel, 1965; Leslie, 1966; Psyche, 1965; Shneidman, 1970a; Westercamp, 1975). Umscheid (1967) outlines various guidelines for helping the nurse increase her skill in controlling her emotional response.

Several articles deal with furthering the role of the nurse in suicide intervention. Marshall and Finan (1971) describe an experiment in southwest Vermount where a group of nurses were involved in a crisis intervention program. During an eighteen month evaluation, it was found that in 25% of the cases work with suicidal clients was involved.

The authors concluded that "These nurses appear able to identify the potentially suicidal patient and are extremely flexible in their intervention" (p. 47). Wolford (1965) outlined several ways for nurses to become implicated in community care for the suicidal person. Multidisciplinary measures as well as follow-up are emphasized. In a similar vein, Clemmons (1971) also suggests ways for greater nurse involvement in the community. A program in the District of Columbia is delineated, which employs nurses in suicide prevention and emergency mental health consultation. This service offers the option to the nurses and patients of a home visit.

Home care is the focus of several articles dealing with a combination psychiatric and public health care nurse. Leslie (1966) describes the role of the public health nurse as preparing the suicidal patient before entry into the hospital and preparing the patient's family for the patient's eventual release from the hospital. Most commonly, several nurses who have participated in the LASPC program for home visits have described their involvement and the importance of it. Several articles have pointed out that the nurse can demonstrate an interest in the patient while assessing the home situation more clearly for patients who would not normally be reached by the activities of the LASPC (Bell, 1970; Farberow & Palmer, 1964; Wallace, 1967). Kloes (1968) goes a step further by summarizing six patient profiles where the nurse, while on a home visit, can provide specialized support and care.

The preceding section has emphasized how nurses can be a vital member of a team intervening with suicidal people. Nurses are urged to become even more involved in an expanded community role. However, the importance of nurses realizing the influence of their own feelings in interactions with suicidal patients offers guidelines that can be utilized by all gatekeeper groups.

Policemen

Police aspects of dealing with the suicidal person are largely devoted to emphasizing the need and inevitability of police involvement and to providing general knowledge that will aid law enforcement officers in their interactions with suicidal people. Murphy, Clendenin, Walbran, and Robins (1969), in studying the role of the police, conclude:

> It appeared from this study that the police are in a crucial position with respect to suicidal individuals, and that a close working relationship between the police and S. P. [suicide prevention] agencies is of fundamental importance. (p. 269)

The necessity for integrating the police into the community network of helping agencies is supported by: Murphy, Clendenin, Darvish, and Robins (1971) in a study of 408 police investigations of suicidal behavior; Mann's (1971) exposition on the establishment of a mental health consultation program with police departments; and tangentially by Nelson (1972) in investigating the community views of a suicide prevention center.

The present functions of the police in acts of suicidal behavior are several: seeing that proper medical treatment is received, protecting lives and property (the suicidal person's own life), investigating suicidal incidents, in some cases law enforcement (where suicide is a crime) and custodial care. In fact, until 1972 in Canada, attempted suicide was a criminal offense; in 1967, 440 people were given suspended sentences for attempted suicide in Canada (Report, 1976, p. 337).

In an attempt to educate the police officer to the mental health aspects of suicide intervention and to the police's role in the intervention, at least two articles have been written, Litman (1970c) and Farberow and Shneidman (Note 9). Both emphasize the need for understanding the victim:

> The recognition of the fact that the individual who attempts suicide must be viewed not as a criminal or bungler but rather as an emotionally disturbed person informs the police officer that he needs to employ special attitudes of tolerance and restraint and special understanding pertaining to emotional disturbance in dealing with such persons. (Farberow & Shneidman, Note 9, p. 9)

As in other gatekeeper groups, special aspects of police work are illuminated: feelings aroused in the police officer, special jail cases (eg. a respectable citizen arrested for a shameful offense), and the need for slow, cautious action. In conclusion, the police can function as effective community gatekeepers if they are given proper human relations training and integrated with other community resources in a teamwork approach to suicide prevention.

Clergymen

Although clergymen have long been known as community gatekeepers, it has only been recently that attention has been paid to this group as interveners in a suicide crisis. In 1960 a Joint Commission on Mental Illness and Health in the United States found that 42% of a sample of over 2,000 people would turn first to a minister in the event of serious emotional problems (Lum, 1974, p. 91). However, a much lower usage of the clergy is reported in Snyder (1971) who found that only 9% of a sample 550 people turned to clergymen for help; the clergy were fourth in preference after family, friends and physicians. Whatever figure is used, the clergy do have an important role in suicide intervention, prevention and postvention (Lum, 1974; McGee & Hiltner, 1968; Pretzel, 1972, 1973; Snyder, 1971; Stone, 1972). Although clergymen can be natural community gatekeepers, Lum (1974) in a study sponsored by the LASPC indicated that few pastoral counsellors have had little experience with suicidal parishioners.

Because church attitudes are changing toward suicide and society is increasingly mobile, clergymen have assumed a slightly different function in suicide prevention as McGee and Hiltner (1968) point out, "There is nothing new about the preventive activity of the clergy except the new insights made available on how to go about it" (p. 3). Further, as Pretzel (1973) concludes after studying the religious beliefs of suicidal persons, the tendency to suicide is very often related to religious despair, since often God does not exist in the reality of the suicidal person. The pastoral counsellor can intervene at this point to offer hope, the promise of God's love. Lum (1974) goes further and sees ministers becoming involved in local suicide prevention centers, as well as acting as catalysts to the church and community as a whole.

Informative guidelines for the clergyman in his role as a gatekeeper for suicidal people have been written (McGee & Hiltner, 1968; Stone, 1972). A major book on crisis intervention has been published for the clergy (Lum 1974). The usual crisis intervention practices are outlined as well as ways for the clergy to get more involved (such as providing support after hospitalization), proper referral and the use of church groups to provide support. To reiterate, clergymen can expand their function as community gatekeepers with suicidal people with added training.

Summary

The preceding pages have summarized what is known about and what is offered to various gatekeeper groups. Certain broad themes that will be followed up in the present study have been identified.

In the section on attitudes toward suicidal people various authors have given some indication of gatekeeper variables that influence attitudes. Occupation (Ansel & McGee, 1971; Beswick, 1970; Ramon et al., 1975), religion (Beswick, 1970; Leshem & Leshem, 1977) and contact (Sale, et al., 1975) have all been indicated as possible influential variables. The following research will attempt to confirm (or reject) these indications and further answer the query, "What other gatekeeper variables (eg. age, sex, past training, experience with suicide) and what quantitative aspects of the interaction with suicidal people (eg. number of suicidal people seen per year, whether any clients have committed suicide) contribute to gatekeeper attitudes toward suicidal people?"

The second section on training has pointed out this need for further education as being basic in future gatekeeper involvement (see particularly Maris, 1973; Report, 1976). There have been recommendations given for future training programs (Allen, 1976; Danto, 1976; Farberow, 1969, Heilig, 1970; Kelly, 1973; Steele, 1975; Berman, Note 2) and actual programs have been offered in a few cases (Cohen, 1974; Resnik, 1973; Thompson, 1974). The following survey will attempt to begin to answer the need for further training as based on research of the present role of the community gatekeeper.

Thirdly, as has been repeatedly indicated in the review of specific gatekeeper groups and case management of the suicidal person, the relationship between the gatekeeper and the suicidal person is the key to any growthful interaction with a suicidal person. Although recognition and assessment occupy fundamental roles in beginning an interaction with a suicidal person, the intervention process is the most essential part. The nature of this relationship and especially the role of the gatekeeper will begin to be probed in the following research. Implications for further training is the intended goal; any findings that indicate a discrepancy between what is presently being done in the local field and what could be done will be used as a basis for training suggestions.

Additionally, the foregoing chapter has intimated that gatekeepers exist as a cohesive group—in regards to the qualitative or emotional component of their relationship with a suicidal person—and as a number of groups in the procedural, job-specific parts of the relationship. This broad theme will be examined by dividing the sample in parts of the subsequent research into various gatekeeper groups. Training suggestions may then be offered on a more practical, job-oriented basis.

CHAPTER III

METHODOLOGY

Description of the Sample

The questionnaire was administered to two groups of participants. One group attended a two-day introductory suicide prevention conference on April 4 and 5, 1977 (see Appendix B). The second group took part in a two day advanced workshop on suicide prevention on April 5 and 6, 1977 (see Appendix C). The participants in the advanced workshop had to have attended an introductory conference that was held on January 26, 27 and 28 of 1976. Both conferences and the workshop were sponsered by AID Service of Edmonton and the United Way of Edmonton. Speakers for the 1977 conference and workshop were invited from the Los Angeles Suicide Prevention Center (LASPC). As well, times were set aside for participants to share information and resources with each other.

The total number of participants in both the conference and the workshop (the Total Group) was 267. Of these, 97 or 36% responded to the questionnaire. Table 1 presents demographic data for the total group of respondents (Group T). From Table 1, the typical respondent was: female, married, Caucasian, under 30 years old, working in a large city in Alberta, a somewhat religious Protestant, and had some post-secondary training.

Of the 180 participants at the conference, 67 (37%) chose to respond to the questionnaire. Approximately the same proportion of the advanced workshop particpants responded, 34% or 30 out of 87 people.

TABLE 1

TOTAL GROUP

DEMOGRAPHIC DATA

1. Sex: Male 26% Female 74%
2. Marital Status: Single 31% Married 57% Divorced 7%
   Separated 3% Widowed 2%
3. Race: Caucasian 97% Indian ____ Metis 3%
   Other (specify) ____________________
4. Age: Under 20 1% 21 - 30 56% 31 - 40 19%
   41 - 50 16% 51 - 60 7% Over 60 1%
5. Highest level of education attained:
   Completed Junior High School 1%
   Completed High School 6%
   University undergraduate degree 17%
   University graduate degree 21%
   Some college or university courses 32%
   Other (specify) 22% (commonly R.N. degree)
6. Do you work in a:
   76% city with a population over 250,000
   9% city with a population under 250,000
   10% town
   4% rural area
   1% other (specify) ____________
7. Are you an Alberta resident? Yes 91% No 9%
8. What is your religious background? Protestant 58%
   Catholic 31% Jewish 1% Atheist 3%
   Agnostic 4% Other (Specify) 2%
9. How religious do you consider yourself to be? Antireligious 4%
   Very religious 17% Somewhat religious 39%
   Slightly religious 21% Not at all religious 19%

Thirty-six per cent of the males and 38% of the females of the Total Group answered the questionnaire.

The occupational groupings represented were those taken from Resnik and Hathorne (1973), Suicide Prevention in the 70s. (See Table 2 for a list of occupational types.) The number of people by occupation at both the conference and workshop, and the proportion of each occupatonal sub-group responding to the questionnarie are respresented in Table 3. As can be seen, of the larger groups represented, nurses, volunteers and students repsonded most often. The majority of Category 1 (Table 2) were actually from the coroner's office rather than practising physicians.

A question on "the number of years in present occupation" (see Appendix D) revealed a majority of people that had been in their occupations for a relatively short time. Fifty-four per cent of Group T had been in their present occupations five years or less. Twelve per cent have had their present jobs for 6 to 10 years and 19% had been at their jobs for over 10 years. Again, responding to how long they had been involved in working with suicidal people, answers in the 1 to 5 year range predominated (52%). Ten per cent have had no experience with suicidal people while 6% have had less than 1 year experience. There is a strong minority who seem to have had a fair amount of experience: 15% had between 6 and 10 years of experience and 13% had over 10 years of experience. Some nurses reported as many as 24 to 40 years of experience with suicidal people.

For purposes of description of the sample, both conference and

TABLE 2

LIST OF SUICIDE PREVENTION OCCUPATION TYPES[a]

1. Physicians—includes general practitioners, psychiatrists, medical examiners/coroners.

2. Behavioral scientists (pure and applied)—psychotherapists, counsellors, directors of mental health agencies.

3. Social workers—includes workers in mental health (child care therapists, paid crisis center workers, family aides, etc.).

4. Nurses—includes public health, instructors, emergency ward, psychiatric.

5. Clergymen.

6. Policemen—includes probation officers.

7. Volunteers—in all mental health areas.

8. Mental Health Trainees and Technicians.

9. Artists—eg. medical illustrators.

11. Teachers—at all levels.

13. Students.

14. Businessmen and industrialists.

15. Special Categories—all people not contained in the above categories, eg. homemakers, sales clerks, secretaries, construction foremen.

[a] After Resnik and Hathorne (1973), p. 25.

TABLE 3

TOTAL GROUP PARTICIPANTS AND QUESTIONNAIRE RESPONDENTS BY OCCUPATIONAL TYPES

Category		Number of Participants	Number of Respondents	Per Cent Responding
1	Physicians	6	2	33
2	Behavioral Scientists	30	11	37
3	Social Workers	81	24	30
4	Nurses	53	30	57
5	Clergymen	3	1	33
6	Policemen	3	2	67
7	Volunteers	24	16	67
8	Mental Health Trainees	2	2	100
9	Artists	1	0	0
11	Teachers	5	0	0
13	Students	13	6	46
14	Businessmen	1	0	0
15	Special Categories	29	3	10
	unknown	15	0	0
	TOTAL	267	97	36%

advanced workshop respondents were considered as one group. The explanation for this choice of presentation will be found more fully covered in later sections of this thesis. Briefly, few significant differences were found between those participants who attended the conference and those who attended the advanced workshop.

Semantic Differential

Charles Osgood and his associates (Osgood, Suci, & Tannenbaum, 1957; Snider & Osgood, 1969) developed the semantic differential (SD) originally as a method of quantitatively studying "meaning." They wanted an instrument which met the measurement criteria of objectivity, reliability, validity, sensitivity, comparability and utility. What finally evolved was "to divide the total representational mediation process into a set of bipolar components, the meaning of a sign corresponding to the pattern and intensity with which these components are elicited" (Snider & Osgood, 1969, p. 67). Perhaps more correctly, as Oppenheim (1966) points out, the technique, a slection of rating scales, can be put to any particular purpose. In this case, the SD was utilized to form a judgment of the attitudes of community gatekeepers toward certain concepts.

The SD consists of a series of bi-polar rating scales (scales such as good-bad, moral-immoral), each extreme being defined by an adjective. The respondent is given a set of scales and asked to rate a number of concepts on each of the scales. Osgood and his associates found, from factor analytic studies, that such ratings of concepts yielded three major factors—evaluation, potency and activity.

The technique was seen by Osgood et al. (1957) to be a reliable and valid measure of attitude. Test-retest coefficients of reliability averaged .91 (Osgood, et al., 1957, p. 192). The evaluation factor was seen as having face validity for measuring attitudes and was cross-validated with at least two other attitude measures, Thurstone scales and Guttman scales.

Basically, regarding studies on suicide, the SD has been used in two fashions. The first involves attempts to distinguish suicidal patients from other populations by utilizing their attitudes to various concepts. The second use of the SD has been to assess attitudes to suicide among gatekeepers and other groups.

Ganzler (1967) first used the SD in a comparison study of a sample of suicidal women clients at a suicide prevention center with clients at the same center who were not suicidal. The suicidal clients, as opposed to the non-suicidal clients, rated the concepts "nothingness" as less negative; "life" and "not being alive" as more positive. Blau, Farberow, and Grayson (1967) found that the concepts "life" and "death" using 4 scales, were inadequate in distinguishing between suicidal and non-suicidal psychiatric patients. However, Neuringer (1968) found differences in attitude toward "life" and "death" among similar populations. Neuringer's results indicated that suicidal subjects saw greater differences between life and death; "the suicidal group considered it [life] as being more positive [and death as more negative] than did any of the other subjects" (p. 62). In a related study, Spiegel

(1969) found that psychological response variables (the SD) and autonomic reactions (Galvanic Skin Responses) were related to each other and to differential suicidal histories (eg. attempters, threateners). Also related to Neuringer's work, Lester (1971) found that attitudes to the concepts "life" and "death" among non-disturbed populations were the same.

Neuringer (1970) evaluated suicidal attempers' responses to the concepts "life" and "death" to discover if changes took place over time. The author concluded that over time the subjects' attitudes to death became more negative; however, attitudes to life did not become more positive. Neuringer and Lettieri (1971) continued along this line of investigation and found that attitudes to "life" and "death" using the SD differed depending upon the initial lethality of a Suicide Prevention Center's clients. Highly lethal suicidal clients thought more dichotomously than other groups. Neuringer (1974a) varied the concepts used, utilizing "myself" and "other people" in a study of the attitudes of suicidal, psychosomatic and normal patients. Again, the greatest divergence between views of "self" and"others" was found among the suicidal population. Wetzel (1975) furthered this work by demonstrating that ratings of the concept "myself" could identify changes in suicidal risk. Similarly Wetzel (1976) attempted to replicate several earlier studies. Patients at emergency rooms (suicide attempters, threateners and control patients) were asked to gauge their responses on 15 scales to 10 concepts, and asked to do the same after 1 month. He found that extreme (dichotomous) rating scores did not discriminate between suicidal and psychiatric controls. However, to support Neuringer and Lettieri (1971), suicidal subjects rated "myself" and "life" significantly less favorably than did the control group. As well, highly suicidal subjects could be differentiated from less suicidal subjects by their rating of "life."

The second use of the SD has concerned various group attitudes to some aspect of suicide. As part of a larger study Snavely (1969) employed the SD to find out what prompted clinical decisions about suicidal clients. Potkay, et al. (1973), with pre- and post-performance scores for a play about suicide, found that subjects (University students) consistently rated "me" more positively than they rated any of the subjects in the play. In a study closest to the present thesis Ansel and McGee (1971) tried to distinguish among group (gatekeeper) attitudes to suicide attempters using the SD. The simulated case histories were rated on four evaluative bipolar adjective pairs: good-bad, high-low, positive-negative, and reputable-disreputable. Although perceived greater intention to die elicited less negative ratings from the total group of gatekeepers, no occupational group differences were discerned. However, small numbers of subjects were used. Nichol (1976) investigated factors affecting negative attitudes towards suicide, rating eight case histories and using the SD. Perceived stress on the suicidal person and the sex of the person exhibiting suicidal behavior influenced the attitudes of the subjects used in the study.

In the present study four concepts were examined—completed suicide, life, death and attempted suicide. Seven scales, termed evaluative, were used to determine attitudes to these four concepts. Good-bad, pessimistic-optimistic, positive-negative and disreputable-reputable were chosen since they all had high factor loadings on evaluation (Osgood, et al., 1957, pp. 53-55). Further, moral-immoral, acceptable-unacceptable and rational-irrational were chosen as experimental, evaluative scales. The order of first presentation of positive or negative poles was varied to reduce simple rote responses. Instructions given were a modification of those suggested by Osgood, et al. (1957, pp. 82-84). Responses were weighted on a 7 point scale, a weight of 1 being given to attitudes on the extreme negative end of the dimension and a weight of 7 to the positive end of the dimension.

In the first instance, the data were factor analyzed to discover whether the first 4 scales and the last 3 differed in factor composition. The MTS (Michigan Terminal System) computer system at the University of Alberta was utilized in this part of the research study. A SEMD01 program, using a factor analysis program, FACT18, as an integral part of the program, was used to obtain a factor analysis. On the basis of this information an analysis of variance test was employed to discover whether any differences existed in attitudes towards the various concepts (ANOV14 on the MTS system).

Finally, a number of analyses of variance tests, using program ANOV15 on the MTS system, were conducted utilizing a variety of groupings to try to discover which aspects of the gatekeeper's role and personal experiences influenced attitudes toward suicide (see Table 4 for the various ANOVAs performed). The groupings were related to

TABLE 4

LIST OF ONE-WAY ANOVAS PERFORMED

1. Group (conference vs workshop).
2. Sex (male vs female).
3. Marital status (single vs married vs other).
4. Age (30 and under vs 31 and over).
5. Education (completed jr. or sr. high vs university degree vs some college or university vs other).
6. Place of work (city over 250,000 vs other).
7. Religion (Protestant vs Catholic vs Other).
8. Religiosity (antireligious and not at all religious vs very religious and somewhat religious vs slightly religious).
9. Occupation (social worker vs nurse vs volunteer vs other).
10. Years in present occupation (less than 1 vs more than 1 but less than 5 vs 5 or more).
11. Years involved with suicidal people (less than 1 vs 1 or more but less than 5 vs 5 or more).
12. Has there been a time in your life when you wanted to die? (yes vs no).
13. How often have you seriously contemplated committing suicide? (very often, only once in a while, very rarely vs never).
14. Have any of the following people in your life ever committed suicide? (member of immediate family, other family member, close friend vs casual friend vs none of these).
15. How many suicidal people would you talk to in your occupational setting during a year? (0 - 10 vs 11 or more).
16. Approximately what percentage of your total work load would include dealing with suicidal people? (0 to less than 10% vs 10% or greater).
17. Have any of the suicidal people that you have dealt with in your occupational role committed suicide subsequently or during treatment? (yes vs no).

quantitative or category responses given to questions in the various sections of the questionnaire. For example, #7 in Table 4: 56 Protestants, 30 Catholics and 10 others (Jews, Atheists, Agnostics and others) responded to the demographic query on "Religion." These 96 people were broken down into 3 groups to be contrasted with one another using one-way ANOVAs to determine whether religion influenced attitudes toward the concepts "completed" and "attempted" suicide.

Shneidman's Survey

In 1970 Shneidman and his associates published a questionnaire on death which included a sub-section on suicide. In the present study, various questions from this questionnaire were utilized with a view towards otbatining more information about community gatekeepers' experiences with suicide. In this section various previous uses of Shneidman's survey and modifications thereof will be examined. The present use in this study will also be discussed.

An overwhelming 30,000 people responded to Shneidman's original questionnaire. Subsequently other authors made use of Shneidman's material either in the original form or in a modified version. Weigand (1972) employed the survey and compared the results from Shneidman's respondents with a group of physician responses. Certain results led Weigand to conclude that, because of their attitudes alone, physicians may be more prone to suicide. Weis and Seiden (1974), again using the original survey, compared volunteers and suicide attempters. Volunteers emerged as more stable and self-content. As part of a one-hour interview with people in Los Angeles communities, Kalish, et al. (1972, 1974) utilized a modified version of Shneidman's study to explore community attitudes towards suicide. Ginsburg (1971b) again as part of a community probe on attitudes toward suicide, used Shneidman-like queries.

In the present study 8 questions were chosen from Shneidman's original 75. These inquiries dealt most directly with personal experiences and feelings about suicide, orienting the respondent to the fourth part of the questionnaire where even more extensive questions would be asked regarding professional experiences with suicidal clients. To statistically test to see if the results from Shneidman's work and the present paper differed, chi-square tests of goodness of fit were employed (Ferguson, 1976, pp. 192-195).

Questions

The bulk of the questionnaire (Appendix D) consisted of a variety of questions suggested by the work of Resnik and Hathorne (1973) and the Report (1976). The dimensions of the questions ranged from time considerations (past, present and future) to professional observations (experiences, needs and recommendations) to reactions (emotional and procedural) and from quantitative to qualitative reports. A variety of responses from the gatekeepers' perspective were extracted; all reflect in some way on the gatekeeper's role in the community.

Responses to questions in the fourth section of the questionnaire were examined using a combination of methods. Trends in the replies that provided clues for devising further training programs were sought and discussed. Differences among occupational groups were reported where appropriate; often insufficient numbers precluded statistically analyzing disparate answers to the various queries. Four occupational groups were used: nurses (N=30); social workers (N=24); volunteers (N=16); and "others" (N=27), representing the remainder of the total group of respondents (see Table 3). Variants in responses will be noted as a possible indication for specific training topics geared to professional groups, rather than gatekeepers as a whole.

CHAPTER IV

FINDINGS AND DISCUSSION

This chapter will examine and discuss the results derived from the questionnaire described in Chapter III. The first section will present the data from the semantic differential scales and will attempt to discuss these results keeping in mind the future training of gatekeepers. This section will be followed by an examination of the data produced using part of Shneidman's survey, comparing his results with the findings of the present survey. The data will be discussed with a view toward further exploring the role and personal experiences of gatekeepers with suicide. The final section will attempt, in a descriptive survey, to present and discuss the role of the gatekeeper, commenting upon any discrepancies between recommended and actual practice and between various gatekeeper groups.

Semantic Differential

Research that employed the semantic differential (SD) proceeded in three steps. Firstly, a factor analysis was utilized to see if all seven scales represented one general factor. Secondly, an analysis of variance was used to examine four concepts (completed suicide, life, death and attempted suicide), to discover whether attitudes to the various concepts were in fact different. In the third instance, various groupings of subjects were used in analyses of variance tests to discover some variables that may influence gatekeeper attitudes to suicide and by inference, the suicidal person.

The first task was an examination of the subjects' responses to the seven scales (good-bad, optimistic-pessimistic, negative-positive, reputable-disreputable, moral-immoral, unacceptable-acceptable and rational-irrational) to ascertain whether there was indeed one general factor. A varimax rotation was employed as an intregal part of the computer program used (SEMD01). The result of the rotation, the factor loading matrix, is presented in Table 5. A strong case can be made for the appearance of two factors, one clustering around the negative-positive dimension (including also the scales good-bad and pessimistic-optimistic) and the other factor clustering around moral-immoral (including the scales disreptuable-reputable, acceptable-unacceptable and irrational-rational). However, the size of the common variance (h^2) suggests that there is an appreciable sharing of common factors amongst the scales (Nunnally, 1967, p. 294). Therefore, the question of whether the 7 scales represent one common factor or two factors cannot be conclusively answered.

For the second step in the analysis of the data, three factors were used to test for differences between the concepts. Factor 1 included 3 scales (good-bad, pessimistic-optimistic and positive-negative); Factor 2 included 4 scales (disreputable-reputable, moral-immoral, acceptable-unacceptable and rational-irrational); Factor 3 was a combination of Factors 1 and 2. The range of possible scores for an individual scale is from 1 (extreme negative score) to 7 (extreme positive score). A one-way analysis of variance for differences between concepts revealed a highly significant F ratio. Table 6

TABLE 5

FACTOR LOADING MATRIX

Scales	Factor 1	Factor 2	Factor 3	h^2*
Good-bad	.752	.454	-.037	.773
Optimistic-pessimistic	.733	.370	-.005	.674
Positive-negative	.815	.435	-.011	.854
Reputable-disreputable	.440	.663	.095	.642
Moral-immoral	.329	.769	-.005	.699
Unacceptable-acceptable	.524	.609	-.122	.660
Rational-irrational	.457	.633	-.120	.623

Total variance accounted for = 70.365%

*h^2 = communalities

presents the means for the various concepts utilizing Factor 1 scales and the results of a Newman-Keuls comparison to test for significant differences between the means. Again, for Factor 2 the F ratio was highly significant. Table 7 represents a similar presentation for Factor 2 as that used for Factor 1. The results of the combined factors, termed Factor 3, are displayed in Table 8.

There was some hint in the review of the literature that perceived intention to die affects a person's attitude toward a suicide attempter (Ansel & McGee, 1971; Dressler, et al., 1975; Ramon, et al., 1975). Therefore, it may be expected that the attitude toward the concepts "completed suicide" (Concept 1) and "attempted suicide"(Concept 4) may very well differ. However, results from this particular study revealed that differences were seen between "attempted" and "completed" suicide only on Factor 1, the evaluative, positive-negative factor (Table 6). When a moral judgment is called for (Factor 2), Concepts 1 and 4 were seen no differently (Table 7). The question of whether there is one common factor or two factors can now be answered somewhat more conclusively. In judgment of suicide, one common factor (Factor 3) appears to be composed of two specific factors: Factor 1, an evaluative factor; and Factor 2, a moral judgment factor, which appears to be the dominant of the two specific factors (see Table 8).

Overall, this particular sample views suicide more negatively than did Ansel and McGee's sample. The mean SD values in the present study, calculated by dividing the total of the 7 scales by 7, were 2.834 for Concept 1 and 3.029 for Concept 4, as opposed to a range

TABLE 6

FACTOR 1

MEANS[a] FOR FOUR CONCEPTS

NEWMAN-KEULS COMPARISONS

Concept

	Completed Suicide	Life	Death	Attempted Suicide
	1	2	3	4
Means	6.742	18.935	12.430	7.806

Newman-Keuls Comparisons

	Concepts	2	3	4	1
	Means	18.935	12.430	7.806	6.742
1	6.742	12.194**	5.688**	1.065*	
4	7.806	11.129**	4.624**		
3	12.430	6.505**			
2	18.935				

** Significant at the .01 level

* Significant at the .05 level

[a] Means for each of the concepts were calculated by adding all of the respondents' scores on the Factor 1 scales for that concept and then dividing by the total number of respondents.

TABLE 7

FACTOR 2

MEANS[a] FOR FOUR CONCEPTS

NEWMAN-KEULS COMPARISONS

	Concept			
	Completed Suicide	Life	Death	Attempted Suicide
	1	2	3	4
Means	13.097	22.419	19.376	13.398

Newman-Keuls Comparisons

	Concepts	2	3	4	1
	Means	22.419	19.376	13.398	13.097
1	13.097	9.323**	6.280**	.301	
4	13.398	9.021**	5.978**		
3	19.376	3.043**			
2	22.419				

** Significant at the .01 level

[a] Means for each of the concepts were calculated by adding all of the respondents' scores on the Factor 2 scales for that concept and then dividing by the total number of respondents.

TABLE 8

FACTOR 3

MEANS[a] FOR FOUR CONCEPTS

NEWMAN-KEULS COMPARISONS

	Concept			
	Completed Suicide	Life	Death	Attempted Suicide
	1	2	3	4
Means	19.839	41.355	31.806	21.204

Newman-Keuls Comparisons

	Concepts	2	3	4	1
	Means	41.355	31.806	21.204	19.839
1	19.839	21.516**	11.968**	1.366	
4	21.204	20.151**	10.602**		
3	31.806	9.548**			
2	41.355				

** Significant at the .01 level

[a] Means for each of the concepts were calculated by adding all of the respondents' scores on the Factor 3 scales for that concept and then dividing by the total number of respondents.

from 3.51 to 3.83 for Ansel and McGee's groups.

The difference between the studies is important. Ansel and McGee used case studies as a basis for measuring attitudes; the present study employs only concepts, not necessarily attached to specific people. Generally, it is believed that attitudes to suicidal people should change while attitudes to suicide itself, as an alternative response to life, should remain negative. As a result, gatekeepers would feel an impetus to help suicidal clients. Such a dichotomy creates problems for any training course. This problem will be discussed later, following the presentation of results for the various analyses of variance performed for different groupings.

Step three involved analyzing what gatekeeper and interactional variables may influence attitudes to suicide. Table 4 in Chapter III presented the various groupings that were tested for significance, using one way analyses of variance. The following variables were not significant in influencing attitudes to the concepts "attempted" and "completed" suicide: training, sex, marital status, age, education, place of work, religion, years in present occupation, years of involvement with suicidal people, contemplation of suicide, closeness of known suicides, number and proportion of work load that is suicidal, and incidence of suicide among clients.

Significance was obtained in only three instances: religiosity, occupation and a gatekeeper desire to die(Items 8, 9, and 12 respectively in Table 4). The results for these groupings are displayed in Tables 9, 10, 11 and 12.

TABLE 9

RELIGIOSITY

ATTITUDES TO "ATTEMPTED SUICIDE"-FACTOR 3

Means for Groups

	Anti Religious and Not at all Religious (N=22)	Very Religious and Somewhat Religious (N=51)	Slightly Religious (N=18)
	1	2	3
Means	24.455	19.823	20.444

Scheffé Multiple Comparisons

Group	Contrasts	F Value	P Value
1 vs 2	4.631	3.303	.0453*
1 vs 3	4.010	1.547	.22
2 vs 3	.062	.050	.95

* Significant at the .05 level

TABLE 10

OCCUPATION

ATTITUDES TO "COMPLETED SUICIDE"-FACTOR 3

Means for Groups

	Social Workers (N=24)	Nurses (N=30)	Volunteers (N=16)	Others (N=27)
	1	2	3	4
Means	20.091	18.567	24.000	18.440

Scheffé Multiple Comparisons

Group	Contrasts	F. Value	P Value
2 vs 1	-1.524	.244	.865
3 vs.1	3.901	1.128	.342
3 vs 2	5.433	2.444	.069*
4 vs 1	-1.651	.264	.8511
4 vs 2	-.127	.002	.999
4 vs 3	-5.560	2.399	.073*

* Approach .05 level of significance

TABLE 11

WANTED TO DIE

ATTITUDES TO "COMPLETED SUICIDE"-FACTORS 1, 2 AND 3

Means for Groups

	Wanted to Die	
	Yes (N=61)	No (N=32)
Means		
Factor 1	7.492	5.313
Factor 2	13.754	11.844
Factor 3	21.246	17.156

Scheffé Multiple Comparisons

	Contrasts	F Value	P Value
Factor 1			
Group Yes vs No	2.179	8.573	.004**
Factor 2			
Group Yes vs No	1.910	4.435	.03*
Factor 3			
Group Yes vs No	4.090	8.831	.004**

* Significant at the .05 level

** Significant at the .01 level

TABLE 12

WANTED TO DIE

ATTITUDES TO "ATTEMPTED SUICIDE"-FACTOR 1

Means for Groups

	Wanted to Die	
	Yes (N=61)	No (N=32)
Means	8.344	6.781

Scheffé Multiple Comparisons

Group	Contrasts	F Value	P Value
Yes vs No	1.563	4.499	.037*

* Significant at the .05 level

In summary, the attitudes of the gatekeepers to "attempted suicide" appear to be influenced by their religious beliefs (Table 9). People who hold strong pro-religious beliefs are inclined to view "attempted suicide" more negatively than people who hold anti-religious or no religious beliefs. Attitudes to "completed suicide" may be partially, at least, a function of occupation; attitudes to suicidal people are also influenced by occupation as seen in a study by Ramon, et al. (1975). Volunteers in the present study tend to view "attempted suicide" less negatively than do social workers and nurses (Table 10). Finally, attitudes to "completed suicide," employing all three factors, appear affected by a gatekeeper's wish for death (Table 11); attitudes to "attempted suicide" are only affected on a positive-negative dimension (Table 12). Those who have wanted to die in the past are perhaps less inclined to view a suicidal act negatively.

Equally revealing are the variables that do not appear to influence attitudes to suicide, particularly training. That is, people who attended the workshop on suicide prevention had previously attended a conference on suicide prevention, yet their attitudes towards suicide remain unchanged. As well, no differences were seen between groups who differed in the following: education, length of experience with suicidal people, degree of experience with suicidal people (by number of clients seen and per cent of work load), personal serious contemplation of suicide, degree of personal closeness to people who eventually committed suicide and in whether or not they had had clients who subsequently committed suicide.

A few conclusions may be tentatively offered from these results. Some gatekeeper variables, notably religiosity, occupation and a desire to die, appear to influence attitudes towards suicide. Moreover, from the literature, support has been found for the conclusion that attitudes to concepts, "completed" and "attempted" suicide, are at least partially correlated to attitudes to suicidal people. It is difficult at this point to predict where attitude fits in as a determinant of behavior, for as Oppenheim (1966) points out, "Behavior is a function of the interaction between P [all the person's inner determinants, such as temperament, attitudes, or character traits] and E [all the environmental factors, as perceived by the individual]" (p. 153).

Shneidman's Survey

The two samples, Shneidman's and the present survey's, were fairly similar in regards to: sex, age, education, religious background and self-report of religiosity. The only major difference was marital status. While 31% of the present sample were single, 53% of Shneidman's sample were single. Fifty-seven per cent of this sample were married, as contrasted with 39% of Shneidman's sample.

The percentage proportions of the responses of the two samples are presented in Table 13. No figures were given in Shneidman's report for Question 5; however, two other sources of information concur with the present study's final figures. Kalish, et al.(1972, 1974) reported that in answer to the query, "Has anyone you've known well [emphasis mine] committed suicide?", 21 to 30%, depending on educational

TABLE 13

ATTITUDES TOWARD DEATH AND SUICIDE

A COMPARISON OF TWO SAMPLES

S[a]	B[b]		
		1.	How often have you been in a situation in which you seriously thought you might die?
25%	1%	A.	Many times.
	13%	B.	Several times.
50%	62%	C.	Once or twice.
25%	25%	D.	Never.
		2*	Has there been a time in your life when you wanted to die?
2%	2%	A.	Yes, mainly because of great physical pain.
37%	42%	B.	Yes, mainly because of great emotional upset.
18%	22%	C.	Yes, mainly to escape an intolerable social or interpersonal situtation.
1%	2%	D.	Yes, mainly because of great embarrassment.
3%	6%	E.	Yes, for a reason other than above.
40%	33%	F.	No.
		3.	How often have you seriously comtemplated committing suicide?
25%	2%	A.	Very often.
	12%	B.	Only once in a while.
35%	34%	C.	Very rarely.
40%	53%	D.	Never.
		4.	Have you ever actually attempted suicide?
2%	2%	A.	Yes, with an actual very high probability of death.
3%	2%	B.	Yes, with an actual moderate probability of death.
8%	4%	C.	Yes, with an actual low probability of death.
87%	91%	D.	No.
		5.[c]*	Have any of the following people in your life ever committed suicide?
	0%	A.	Member of immediate family.
	8%	B.	Other family member.
	16%	C.	Close friend.
	43%	D.	Casual friend.
	42%	E.	None of these.

TABLE 13 CONTINUED

S[a]	B[b]	
		6. How do you estimate your lifetime probability of committing suicide?
25%	0%	A. I plan to do it some day.
	1%	B. I hope that I do no, but I am afraid that I might.
	19%	C. In certain circumstances, I might very well do it.
41%	55%	D. I doubt that I would do it in any circumstances.
33%	25%	E. I am sure that I would never do it.
		7.* Suppose that you were to commit suicide, what reason would most motivate you to do it?
2%	0%	A. To get even or hurt someone.
6%	6%	B. Fear of insanity.
24%	31%	C. Physical illness or pain.
5%	7%	D. Failure or disgrace.
31%	29%	E. Loneliness or abandonment.
9%	9%	F. Death or loss of a loved one.
1%	6%	G. Family strife.
3%	2%	H. Atomic war.
15%	26%	I. Other.
		8.* Suppose you were to commit suicide, what method would you be most likely to use?
69%	61%	A. Barbiturates or pills.
8%	6%	B. Gunshot.
1%	0%	C. Hanging.
1%	3%	D. Drowning.
2%	3%	E. Jumping.
1%	2%	F. Cutting or stabbing.
10%	19%	G. Carbon monoxide.
7%	16%	H. Other.

* Some totals add up to more than 100% since respondents sometimes checked more than 1 response.

[a] S=results of Shneidman's survey.
[b] B=results of present study.
[c] No figures were given in Shneidman's (1971) reporting of the results.

background, responded "yes." Twenty-four per cent of the present sample knew someone well who subsequently committed suicide. Further, Ginsburg (1971b), in his research, found that 53% of his sample knew someone who had committed suicide. Fifty-eight per cent of the present subjects knew someone who had committed suicide.

When chi-square tests for goodness of fit (Ferguson, 1975, pp. 192-195) were applied to the results, significant differences were revealed between the two studies on Questions 1, 3 and 6 (Table 14). No significant results were achieved for Question 4. It was not possible to calculate chi-square tests for Questions 2, 7 and 8 since percentage figures totalled more than 100% in each case. However, results appear fairly similar on these three items. In addition, there were no Shneidman data for Question 5.

In summary then, in contrast to Shneidman's sample, this sample of gatekeepers has been in less perilous situations, have less frequently considered suicide as an alternative and are more unsure of their lifetime possibility of committing suicide. Many in the present sample (47%) have considered suicide in the past, and suicide is a possibility, however remote, for many (75%) in the future. The results of the first section of this chapter indicated that certain indices of gatekeepers' personal experience, namely, religiosity, occupation and a desire to die, may influence their attitudes toward suicide. This section further points out that gatekeepers, in large part, have had personal experiences with suicide to use as a basis for better understanding in relationships with suicidal people. Although the

TABLE 14

SHNEIDMAN'S SAMPLE VS PRESENT SAMPLE

DIFFERENCES IN RESPONSES

CHI-SQUARE TESTS

Question 1. "How often have you been in a situation in which you seriously thought you might die?"

Responses	Present Study % (O)	Shneidman's Study % (E)	O-E	$\frac{(O-E)^2}{E}$
A & B Many & several times	14	25	-11	4.84
C Once or twice	62	50	12	2.88
D Never	25	25	0	0
Totals	101	100	1	χ^2=7.72*

* For df=2, χ^2=5.99, therefore result significant at .05 level.

Question 3. "How often have you seriously contemplated committing suicide?"

Responses	Present Study % (O)	Shneidman's Study % (E)	O-E	$\frac{(O-E)^2}{E}$
A & B Very often & only once in a while	14	25	-11	4.84
C Very rarely	34	35	-1	.0286
D Never	53	40	13	4.225
Totals	101	100	1	χ^2=9.0936*

* For df=2, χ^2=5.99, therefore result significant at .05 level.

TABLE 14 CONTINUED

Question 6. "How do you estimate your lifetime probability of committing suicide?"

Responses	Present Study % (0)	Shneidman's Study % (E)	0-E	$\frac{(0-E)^2}{E}$
A-C Might or plan to do it	20	26	-6	1.38
D Doubt that I would do it	55	41	14	4.78
E Sure I would never do it	25	33	-8	1.94
Totals	100	100	0	χ^2=8.10*

* For df=2, χ^2=5.99, therefore the result significant at .05 level.

present sample may not have faced death as often as Shneidman's sample, many have had thoughts about death and suicide in particular. The results from the use of Shneidman's survey therefore again hint at the prevalence and importance of the gatekeeper's personal experiences and familiarity with suicide.

Questions

This third section of the research examined the experiences of the gatekeepers and their needs and recommendations for future changes. The questions addressed themselves to the most pressing of the issues in treatment of suicidal people as disclosed by the literature, relying mostly on Resnik and Hathorne (1973) and the Report (1976).

Originally it was believed that past training may have influenced gatekeeper responses to many of the queries in part 4 of the questionnaire (Appendix D). However, an examination of any differences in the results for the workshop and conference groups, remembering that the workshop group had attended a previous conference, determined that few differences existed either in a quantitative or qualitative sense between the two groups. A disproportionate number of nurses attended the workshop (30/87 or 35%) as contrasted with the conference (23/180 or 13%). As well, 43% of the nurses in the workshop group chose to respond to the questionnaire as opposed to 25% of the conference nurses.

The only other apparent difference between conference and workshop groups was found in responses to Question 13, "Have any of the suicidal people that you have dealt with in your occupational setting committed suicide subsequently or during treatment?" (Appendix D). Gatekeepers who responded to the questionnaire at the workshop were significantly more likely to have lost a client due to suicide than gatekeepers attending the conference. With 85 of 97 people responding, the results between the groups, using a chi-square test, were significant at a .001 level.

In summary, nurses appear to feel the need for additional training, more so than other occupational groups. Furthermore, nurses who have had extra training respond more readily to a questionnaire, feeling perhaps a need for expression of their feelings and opinions or a need to change the poor quality of services offered to the suicidal person in this province. It also appears that people who have more often experienced the death of a suicidal client chose to respond more frequently to a questionnaire dealing with their thoughts and feelings about suicide and suicidal people.

However, for the purposes of the reporting of this fourth section of the questionnaire, a twofold approach will be utilized. Differences between occupational groups will be examined as the first section of this chapter revealed that occupation may be an important determinant of attitudes towards suicide. The following occupational groups will be represented: Nurses (N=30; 8 public health, 7 psychiatric, 4 nursing instructors and 11 general health), social workers (N=24), volunteers (n=16), and "others" (N=27). Secondly, results will be examined to see whether differences exist between what was suggested as optimal gatekeeper behavior from the literature, and what is presently being attempted by gatekeepers working in the field of suicide intervention.

Demographically, the following differences were noted. Twenty-eight out of 30 nurses and 19 out of 24 social workers who responded were female; this is in contrast to 7 out of 16 volunteers and 11 out of 27 "others" who were female. More nurses tended to be married than did any of the other groups. Nurses also had the most years of experience with suicidal people, an average of 9.3 years; volunteers averaged 2.6 years, social workers, 3.7 and "others," 3.7 years. Social workers tended to be younger (70% under 30 as opposed to 50 to 56% under 30 for the other groups) and have had less on-the-job experience, averaging 3.4 years in their jobs, as contrasted with means of 7.1 years for volunteers and "others" and 7.4 years for nurses. Volunteers, who most often reported only "some" college or university courses, appear to be less formally educated than the other groups.

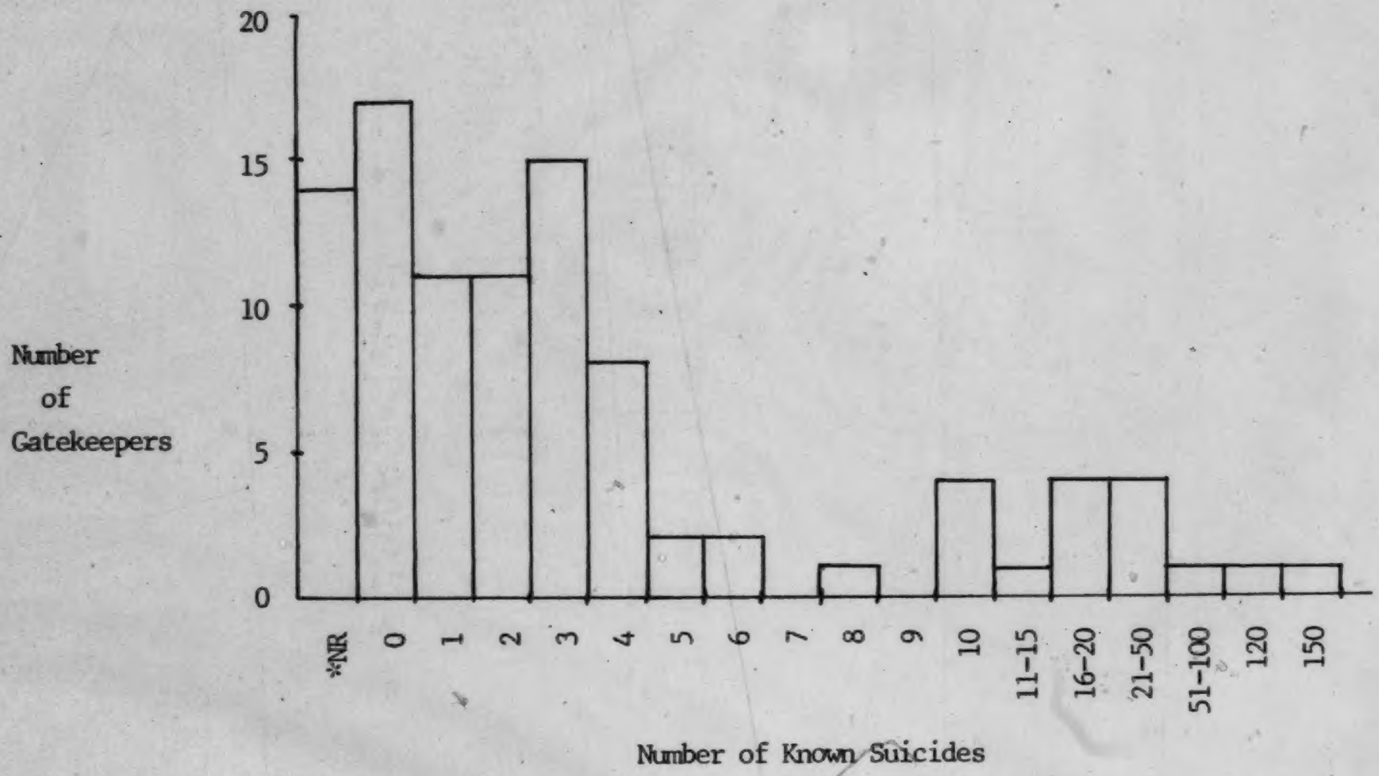
Question 1: "How many completed suicides do you know of in your community within the:

Last month?" In response to the preceding query, 73/97 or 75% of the total group (Group T) did not respond or responded "0."

Last year?" In asking how many suicides were known within the last year, responses were quite varied (see Figure 2 for Group T results). The modal response was 0, the second most common response was 3. Answers ranged from 0 to 150.

FIGURE 2

KNOWN COMPLETED SUICIDES IN LAST YEAR: GROUP T



* NR=No Response

Gatekeepers, whatever their occupation, seem to be little aware of the actual number of completed suicides within their community. For example, in Edmonton from 1968 to 1973, 340 people completed suicide, an average of 57 people per year (Report, 1976, p. 289).

Question 2: "What aspect of suicide are you presently primarily engaged in?"

Respondents showed a breadth of methods of involvement with suicidal people. Forty per cent are engaged in preventative work, 35% of Group T and 80% of the volunteers are involved in intervention and 24% of Group T, primarily public health and psychiatric nurses rehabilitate or do post-vention.

Question 3: "Do you primarily work with one age group?"

Few of the occupational groups were engaged in working with one age group (29%). Of these 26 people, 42% worked with youths (to age 18), 54% dealt with adults and only 4% worked with the elderly (65 and over). The elderly, a population with a high rate of suicide, are probably being largely neglected as a high-risk suicidal sub-group.

Question 4: "What are your methods of contact with suicidal people?"

The methods of contact could be predicted by occupation. Occupational groups, such as nurses had almost 100% face-to-face contact. Others, however, such as volunteers, had 100% telephone contact. But some social services allow for both types of contact. These services are more flexible in terms of client contact and by being so can perhaps meet the need of the client for human contact more often. Public health nurses, counsellors, from the "others" category, and social workers, in large part, fell into this more adaptable group.

Question 5: "How do you usually first come into contact with a suicidal person in your occupational setting?"

Means of first contact with suicidal people varied, again dependent upon occupation. Overall, 39% of suicidal referrals were self-motivated. However, for nurses and "others," only 19 and 25%, respectively, of their patient case-load were self-motivated; 59% and 68% of volunteers' and social workers' clients were self-motivated. Other means of referral were: other agencies (23%), family or friend (17%), or other sources (21%). For those involved in psychiatric work, primarily nurses and social workers, the patient often comes to them through a certificate or warrant signed by psychiatrists. Small minorities of clients are sent by their physician to counsellors, noticed by nursing instructors or brought to emergency.

Question 6: "Describe briefly the usual procedure you presently employ when you first come into contact with a suicidal person in your occupational role?"

The procedures that were used on first contact with a suicidal person were quite varied yet contained some common elements. One of the most common overall procedures was listening. Regardless of profession, this empathic communication technique was chosen most often. "Rapport" was another word used frequently, as was "trust." The focus, across occupations, appeared to be on building a relationship. From this quite prevalent theme, occupations then differed in their approach. Nurses—psychiatric, emergency, and staff—commonly did an assessment, including close attention to physical needs, and then referred patients or continued to watch over them. In a hospital setting, nursing instructors often faced suicidal nursing trainees and the procedure involved: chats over coffee, drawing in family and friends, and/or a referral to a psychiatrist or mental health worker. Public health nurses, on the other hand, could normally establish a closer personal working relationship with patients, using the back-up of their Mental Health Division.

Other gatekeepers, volunteers, social workers, and "others" seemed to have many commonalities in procedure. "Understanding" and "caring" headed the list. The feelings of the client were important and needed dealing with first. Next usually came problem-solving: some contract as to short term goals, discussion of alternatives and arrangement for referral where appropriate. At times some follow-up was arranged to see if what was agreed upon had been carried out. The procedure normally used when a gatekeeper first contacts a suicidal client is best characterized by the respondent who described the process: "1) establish genuine caring relationship, 2) encourage a sharing of experience and anxieties, 3) encourage involvement in seeking help or planning other behavior, 4) gradually withdraw support as person becomes stable, confident and independent." Dependent upon the setting the suicidal person may receive quite different treatment. Commonly some adaptation of a "crisis" model was used by all of the gatekeeper occupational groups.

Question 7: "Is it your present policy to refer the suicidal person to an alternate person or agency in your community?"

The problem of referral is quite acute in suicidal cases. The preceding question was answered "yes" by about a two thirds majority (65%) of the people responding. Most frequent choices of referral agencies or people were the Psychiatric Walk-in Clinic at the University Hospital, Community Mental Health Services, psychiatrists and counsellors. A distinct minority chose an assortment of services depending on the surrounding crises. Nurses most frequently chose the Psychiatric Walk-in Clinic, social workers used a variety of referrals depending on the need and volunteers were more likely to list several choices.

Question 8: "Is there presently in your community an agency or person that you would feel comfortable referring a suicidal person to?"

The services mentioned above may not adequately meet the needs of the suicidal person, therefore, the foregoing question was asked. The great majority of Group T, 86% or 85 out of 97 responding gatekeepers, would feel at ease about referring to someone in their community. Again, the same services were used: the Psychiatric Walk-in Clinic, psychiatrists, Community Mental Health, counsellors, the Holy Cross Hospital (Calgary) Crisis Team, and Distress Line (Edmonton). Specific individuals were also named by a few respondents. There appear to be agencies that gatekeepers feel are equipped to deal with suicidal people. However, as disclosed by the Report (1976), few agencies in actual fact have properly trained staff to deal with suicidal clients.

Question 9: "How many suicidal people would you talk to in your occupational setting during: a week? a month? a year?"

Answers varied widely. Figure 3 charts the frequency of contact with suicidal persons over the course of a year. As can be seen, there appears to be a decided split, with a near equal number of Group T seeing very few suicidal people and another portion seeing a substantial number.

Nurses as a group saw the greatest number of suicidal patients with an average of 57 people per year. "Others" saw the least number of people with an average of 22 per year. Volunteers averaged 41 suicidal clients per year and social workers 51.

Question 10: "Approximately what percentage of your total work load would include dealing with suicidal people?"

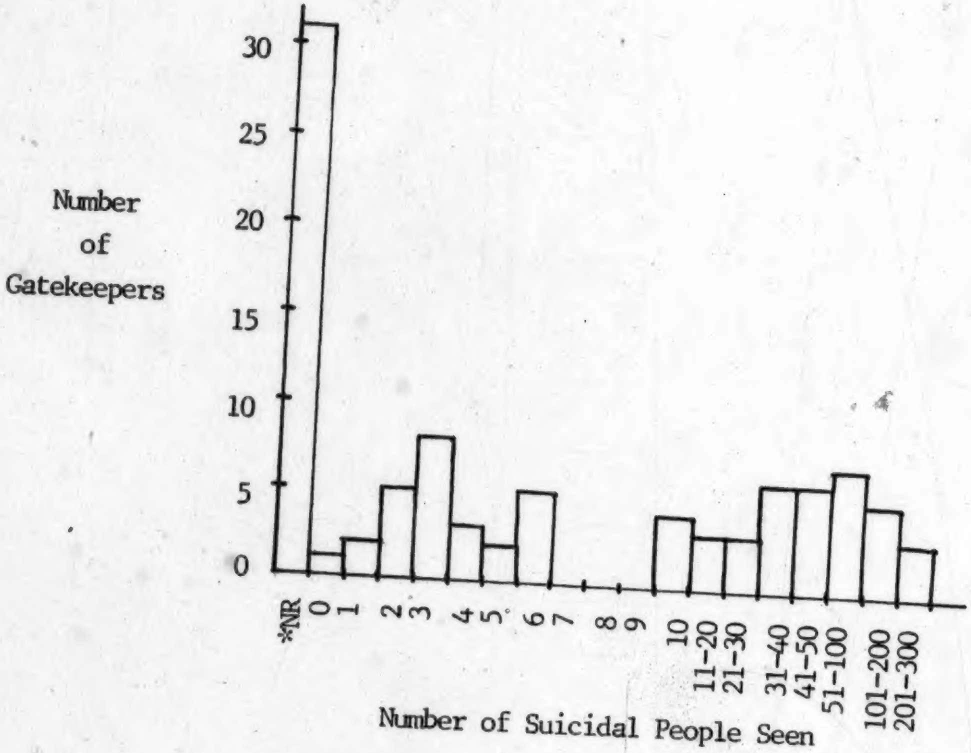
The results of this question indicated few occupational group differences: the range of responses went from an average of 10% for volunteers to 16% for social workers. However, heavy suicidal case loads of from 40 to 80% were reported for a few (8) individuals within the various occupational groups. Time pressures appear to be an important variable in gatekeeper interactions with suicidal people.

Question 11: "How many of the above [suicidal people] (per month) would have A) suicidal thoughts but have taken no actions, B) made suicidal attempts?"

The query was sparsely answered, primarily because few people had responded to the preceding question. Generally, the proportion

FIGURE 3

NUMBER OF SUICIDAL PEOPLE SEEN IN ONE YEAR: GROUP T



*NR=No Response

of clients with only suicidal thoughts, as opposed to suicidal attempts, varied depending not only on the profession but on the actual setting of the work. As would be expected, hospital emergency wards get a large portion of suicidal attempters whereas distress lines, social workers, and quite often psychiatric personnel (nurses and social workers) hear more suicidal thoughts.

Question 12: "Identify one primary emotion you have in your work role when you:

First come into contact with a suicidal person." In specifying one primary emotion, some degree of anxiety, tension, or fear was most often recorded, "great feeling of responsibility and anxiety with this [first seeing suicidal person]." Concern, compassion and sadness were also mentioned as emotional reactions. A substantial minority noted more negative feelings of inadequacy, frustration and anger. One respondent was quite vivid in her description, "disgust and revulsion—sometimes anger"; another recorded a "slight feeling of personal threat." These results do not seem to be dependent on occupational group. Suicide seems to be an issue capable of engendering strong feelings; when confronted with a suicidal person the emotions mentioned in the preceding paragraphs may race through the gatekeepers, adding to an already crisis-laden situation.

Have left the interview." When asked to identify an emotion on leaving the interview with a suicidal client, the opinion of the gatekeepers was split. On the one hand were relief, calmness, confidence and commitment. On the other hand were doubt, apprehension, concern, frustration and worry. Perhaps more correctly, as respondents stated: "[It] depends on [the] outcome, exhilaration or despondence" and "[It] depends on [the] result—from exasperation to satisfaction." Again, belonging to a specific occupational group did not seem to have any bearing on the response.

It appears that dealing with suicidal people is an emotional experience, at best very satisfying, at worst, engendering terrible feelings of helplessness. Small wonder that many people chose not be become involved at all.

Question 13: "Have any of the suicidal people that you have dealt with in your occupational role committed suicide subsequently or during treatment?"

Other problems can be created when the suicidal person commits suicide after or during treatment. Twenty-seven (32%) of 85 gatekeepers had to deal with the loss of a client. No occupational group seemed more prone than any other to the loss of clients through suicide. Again, deep emotional undercurrents were set in motion. Shock, inadequacy, dejection, anger and sadness succeed one after the other. Such reactions may produce feelings of guilt and failure, clouding further gatekeeper interactions with suicidal people.

Question 14: "What is your policy in regards to follow-up of suicidal people who are:

Referred to another person or agency?" The most frequent response was no further follow-up, very little, "unfortunately, not much" (24/73 subjects). However, a sizable minority kept some sort of contact

(21/73). Some kept in touch with the agency or person that the client had been referred to or expected that agency to keep in touch with them (7/73). Other choices included expecting the client to keep in touch (7/73), or using some other person within the agency to keep in touch (3/73). Overall, social workers most often had no follow-up policy. The literature has pointed out the importance of follow-up as a means of meeting the suicidal person's need for continued human contact. However, for many agencies, once a referral is made, little checking is done to see if the client has made contact or if the referral is a good one.

Dischared from your care?" A request for a description of the procedure used after final discharge of a suicidal client brought forth only 52 out of a possible 97 responses, appreciably less than the previous answer. The most frequent response (14/52) was for some sort of informal contact to be kept. The next most popular responses were no follow-up (11/52), or leaving contact up to the client (8/52). No consistent policy appears to be followed by any occupational group. One of Resnik and Hathorne's (1973) recommendations was for an increased emphasis on the the importance of follow-up. If inadequate notice is taken of cries for help, the cries can become increasingly stronger in volume and the seriousness of the suicide attempt can escalate.

Question 15A: "What are the main needs of the suicidal person?"

Many responses were elicited when subjects were queried about the main needs of the suicidal person. The most frequent responses were the need: to communicate, 16% or 34/214; to form a supportive relationship, 16%; to be cared for, 13%; and to be understood, 8%. Other needs mentioned frequently were to increase self-esteem and self-worth, to broaden alternatives and perspectives, to receive a sense of hope, trust, acceptance and empathy. In other words, as one respondent succinctly put it, "[What is needed is] a constant caring other to relieve feelings of isolation." Almost all responses stressed some aspect of these very human needs. There was great variety in the responses. Some were very specific as to the needs of the suicidal community: "24 hour availability of someone to talk with, therapists who are not afraid of suicidal cients and counsellors in all emergency departments." No noticeable differences in responses were seen between occupational groups. In summary, gatekeepers seem to realize the importance of very human, non-institutionalized techniques in dealing with suicidal people.

Question 15B: "Which of these needs do you feel you are meeting?" Gatekeepers replied most frequently, "someone to listen, to hear the communication the suicidal person wished to give." Caring for the suicidal person was also repeatedly mentioned.

Question 15C: "Which of these needs do you feel you are not meeting?"

Although many chose not to respond to this section of the question on needs, some of those who did, responded that a continued relationship and support was often difficult. Gatekeepers do not feel as caring and understanding as they feel is needed by the suicidal person. One respondent answered simply, "I tend to panic a little and have trouble being positive about their life."

Question 16: "How could your present agency/community resources be used more effectively and efficiently to meet the needs of the suicidal person in:

Prevention?" Out of 92 responses 47% stressed some aspect of public or gatekeeper education. Closely related were 23% of the responses devoted to increased publicity of present resources, including dissemination of printed, informative material. Other suggested responses were increased emphasis on follow-up (7%), increased availability of resources (5%), and better inter-agency cooperation and coordination (5%).

Intervention?" Within the realm of intervention, resources could again be used much more effectively according to gatekeepers. Training was the first priority again, this time with emphasis on specific skills, eg. role playing and moving people towards independence and strength (29% or 21/72). Once more, publicity of available resources was frequently mentioned (11%) as were specific means of increasing availability of resources, such as flying squads, and crisis teams in hospital emergency rooms (14%). Follow-up and inter-agency cooperation were lesser choices. As in the previous section on the question of broadening existing resources, no differences were apparent among the occupational groups.

Rehabilitation?" When rehabilitation was focused upon, gatekeepers had further ideas as to more effectual use of resources. Most often noted was more and better follow-up (30% or 23/76) and involvement of significant others: family, friends and community (16%). Others mentioned specific resources for rehabilitation such as half-way houses or agencies for long term care (8%) and improved training (11%). In summary, in prevention, intervention and postvention care of the suicidal person, gatekeepers have sound ideas as to more effective utilization of their agency and community.

Question 17: "What are your needs in connection with the suicidal person that are being met:

In relation to your job?" As part of a two-party relationship, the gatekeeper also has needs. In responding to the preceding query gatekeepers frequently stressed some aspect of job satisfaction (12% or 10/85), such as recovery of the suicidal person or helping the community. In addition, support from and discussion with colleagues (8%), education (9%), flexibility within the job (6%) and adequate consultation and supervision (6%) were noted.

In a personal sense?" A special gratification, an increased sense of worth was one of the most basic needs being filled (60% or 37/62). Gatekeepers have a need to know of their effectiveness, and receive a notable satisfaction when they see others improve and learn to cope. The following responses are just a few examples of this:

> I find it a growing experience for me plus always a learning one and I like and need this. Also I find it fulfills my needs to be a concerned and caring person.
>
> [It gives me a] feeling of well being, great usefulness—elation in helping someone find a hold onto something ultimately precious.
>
> It's a learning, growing, stimulating experience for me.

Related to this personal gratification is heightened self-awareness (5/62). Some fortunate gatekeepers (8/62), have concerned fellow workers, supervisors or consultants, that is, someone else who believes that their feelings and actions are important. No occupational group differences were detected.

Question 18: "What are your needs in connection with the suicidal person that are not being met:

In relation to your job?" For 53 respondents, 19% of the sample, the most frequently stated job dissatisfaction was the absence of any follow-up. Eleven per cent mentioned a lack of support from co-workers and supervisors; 9% found time pressures difficult and not enough personal contact was cited by three social workers as a job restriction.

In a personal sense?" Forty-one responses were given to the question of what personal needs were not being met. A feeling of frustration appeared to stem from several sources: from not being able to do enough (4), from patients who could not do more for themselves (5), from pressing time contraints (4). But primarily these frustrations came from a need to know the results of the relationship (8). As one volunteer best expressed it, "I cannot give so much of me without needing to know [the] outcome after treatment. It's too hard."

Question 19: "Are there any pieces of literature in the area of suicide and suicide prevention that have been especially helpful to you in your work?"

Out of 74 responses, 65% said "no," they had found no literature that had been useful. Of the 35% who replied "yes," the sources most frequently cited were the conference package materials from the January, 1976 Conference on Suicide Prevention, and training within their own agencies. A variety of other sources was also mentioned but included largely bits of information gleaned from a multitude of aids, including books, articles, lectures and films, many of the sources not being directly applicable to suicide. It seems that gatekeepers lack practical literature pertaining to their role with suicidal people.

Question 20: "How do you think high-risk suicidal sub-groups in your community could be reached more effectively:

With present resources?" The most common response, 25% or 17/68, was to educate the public, making them more aware of suicide as a fact of life. One respondent put it best when she stated, "[We need] massive publicity to make people accept suicide as a daily item not something unmentionable." Related to this was a desire for more training for gatekeeper groups (13%). Another frequent reply was to advertise, especially publicizing already existing, available resources (15%). The media was seen by the gatekeepers as a means of reaching people who were most likely to eventually commit suicide. Better agency cordination and intercommunication would also help (6%).

If more resources were available?" With 60 recorded replies, 35% suggested education, or re-education, using the media and focusing on community groups. Closely related to this were forms of outreach programs (12%), using such vehicles as drop-in centers and flying squads. Twenty per cent of the subjects emphasized the need for more personnel in the whole mental health field. Gatekeepers remarked on the need for the advertising of present resources (7%) as well as help for the chronically suicidal in the form of group therapy and self-help groups (5%). It appears that community services can become more available to other groups to begin a public dialogue on suicide, to speak to groups to get things moving. According to the gatekeepers there are many ways of getting social action started. But all this means much work and an active taking of the initiative, something that has not yet happened.

Question 21: "Would you be willing to keep records of your contacts with suicidal people to send to a central bank for research purposes?" Only 24% of Group T replied "no." Forty-eight per cent would only record such data under certain circumstances. The most favored condition of reporting data was if confidentiality was assured (44% or 18/40). Another condition sometimes sought was permission of the employer or agency (17%) or permission of the client (10%). Some mentioned time restrictions (19%), "I would not be willing to complete one of these forms for each." Twenty-nine per cent answered "yes," they would be willing to take note of suicidal clients. These gatekeepers saw a need for more accurate information as an educational tool and as a means to ultimately helping others. Of the 24% who replied "no," a variety of reasons was given: work load-time considerations, too few suicidal cients seen, agency policy of complete confidentiality and that the agency, rather than the person, was responsible for statistics.

Question 22: "Do you believe that people not specifically educated and trained should be involved in programs of suicide intervention and prevention?"

The forementioned question was perhaps poorly worded. The intent of the writer was to enquire about the future use of volunteers in programs of suicide prevention. As the question stood, 63% of Group T said "yes" and 37% replied "no."

Question 23: "Are volunteers presently an integral part of your agency functioning?"

Volunteerism was clearly a part of this query. Forty-nine per cent of the people presently work in an agency which employs volunteers. This group was mainly represented by volunteers (100%) and social workers (62%); nurses (22%) and "others" (30%) had less contact with volunteers. The most frequent use of volunteers is to man distress phone lines or crisis services (21/37); commonly volunteers make up part or all of the manpower of a social service agency (27/37). Although noted infrequently, volunteers also provide one-to-one post-treatment care, easing suicide attempters back into the community (3/37).

According to the literature, volunteers are the new wave of the future in social change. So respondents were asked how volunteers could be used in the years to come with the suicidal community. An oft-repeated function (51% or 34/69) was for them to "be 'friends,' to follow-up person and show interest and care," "as 'community friends' for isolated, lonely people." That is, people who are under fewer time constraints could devote this time to keeping in touch with the suicidal person. Further, volunteers should be encouraged to continue to staff distress lines/crisis services (22%). Volunteers could also be used in outreach programs, especially in home contacts.

Question 24A: "Do you feel that a Suicide Prevention Center is needed in Alberta?"

In 1976 the Report of the Task Force on Suicides in Alberta recommended the establishment of a "Designated Center" for suicide prevention (p. 95). Gatekeepers were asked if such a suicide prevention center was needed as far as they were concerned. An overwhelming 96% (82/85) responded "yes."

Question 24B: "If yes, what would be the major resources that you would expect a Suicide Prevention Center to provide:

To you personally?" Gatekeepers listed, in order of frequency of response to this part of the question: training/information (28), consultation/support/back-up (18), resource for referrals/referral (16), and 24 hour service/availability (9).

To you in your occupational role?" Gatekeepers, in their occupational roles, would like a resource for referrals/counselling center (34) and consultation/support (15).

To your agency?" For their agency, training/information (25), a resource for referral/counselling (20), consultation (7) and a mobile unit (6) were suggested.

To your community?" To serve the community such a center would need to offer many services, among them: public education (16), availability/24 hour service (15), resource for referral/place for referrals (10) and mobile unit/flying squad (6).

In summary then, a suicide prevention center would primarily be an accessible source for assistance to gatekeepers in the areas of training, accepting referrals and on-going guidance regarding suicidal clients. A much needed potential community asset has again been supported in this survey as a necessity, corroborating the Report's (1976) recommendation for the establishment of a "Designated Center." A "Center" as has been outlined can only be achieved through concerted public pressure and initiative. Gatekeepers may have a key role to play in beginning such a social service.

Question 25: "Do you feel further training in the area of suicide prevention should be directed to: your occupational group? an interdisciplinary group?"

As regards further training, 38% of the gatekeepers would like to see workshops directed to their occupational groups whereas 63% would like education aimed at an interdisciplinary group. Occupational differences can be seen in the responses to this query. Nurses (57%) and volunteers (50%) prefer training directed at their profession, while social workers (77%) and "others" (77%) desire training at an interdisciplinary level.

Question 26: "Will you be disseminating the knowledge and skills gained at this conference/workshop to your: fellow workers? community?"

Ninty-eight per cent of the group who responded, 84 out of 97 people, indicated that they will be passing along the skills and information gathered at the April, 1977 workshop/conference to their fellow workers. Only 63% of the 56 people who responded to this part of the question noted that they may be educating the community as a whole.

To their fellow workers, gatekeepers may be: giving inservices, workshops or mini-conferences (33%); presenting reports at staff meetings (26%); informally discussing their experiences in conversations (29%); or disseminating the materials presented as part of a conference package (9%). Few suggestions were offered for community propagation; those that were, included community forums or publicizing gatekeepers' availability to speak to community groups. Informal discussion and increased awareness with clients were also noted.

Gatekeepers see themselves as teachers for their fellow workers but do not yet see their full potential for community involvement. It is only, as they have noted so frequently in other parts of the questionnaire, when the public is truly re-educated that suicide prevention can adequately proceed. Until many peoples' belief systems are reached and changed, suicidal people will continue to be shunned with increasingly tragic results.

Summary

Gatekeepers, from the results of this survey and as revealed by the literature, occupy a very difficult, yet potentially very important position in communities that are seeing a marked increase in the tendency to self-destruction ("Tragedy reflects suicide," 1979). The preceding survey has attempted to more closely define the role of the gatekeeper in the community and in so doing enlarge upon possibilities for future social action by gatekeepers within a local context. From the research, it appears that gatekeepers may be influenced in their interactions with suicidal people by their occupation, their religious preferences and their death wishes. As well, many gatekeepers have indicated thoughts about and contacts with suicide. These personal orientations and determinants of their attitudes all have to be taken into account in gatekeeper education.

The responses to this questionnaire have indicated that a solid basis for future training of gatekeepers exists. Topics that can be shared and ideas that can be expanded and initiated into reality have been presented in the replies to numerous queries. An attempt will be made in the following chapter to synthesize these suggestions of the gatekeepers into a useful plan for further discussions and training.

CHAPTER V

LIMITATIONS AND RECOMMENDATIONS

This chapter included three sections. The first deals with the limitations of the present survey. This will be followed by a synthesis of Chapters II and IV into recommendations for a proposed training program. The findings of the questionnaire and the suggestions of the literature will be combined to form the plan for future gatekeeper education. The third section of the chapter attempts to point out areas needing further research investigations and development.

Limitations

The prime limitation of the study is seen in the possible non-representativeness of the sample. According to standard texts on sample survey design, the gatekeeper group that responded represent a nonprobability, haphazard sample. Results from such samples are limited in their generalizability. There is a very real question as to whether the gatekeepers that answered the questionnaire are characteristic of the total population of gatekeepers. The answer is, of course, probably not. Certain subgroups, such as doctors, policemen and clergymen were very underrepresented at the conference/workshop. The Indian and Metis population of Alberta, in particular, were seriously underrepresented. These native people have an estimated suicide rate twenty times the rate of the white population. Other gatekeepers who already have training, were not even in attendance at the suicide prevention sessions. The people who did reply had to respond to a lengthy questionnaire, coming as it did during or after an intense learning experience. There were more than likely undetermined biases in those who did respond, as they were self-selected, volunteer subjects.

However, despite the above limitations surrounding the general factor of representativeness of the sample, the rationale for using such an instrument can be offered. The present survey was meant to be primarily a preliminary, descriptive study, illuminating further the role of the gatekeeper in the community. As such, little guidance exists in the literature as to what had been done in studying the community role of the gatekeeper with a view toward further education. Therefore, the questions in the present study were tentative, written with future training in definite areas and to specific groups in mind. Gatekeepers, already practising in the community could give a useful indication of their ideas and experiences with suicide that could be utilized in planning further educational programs for other gatekeepers. An experimental training model will be produced and will, in all probability, be further revised as training actually begins and a certain group of people respond to the program.

Proposed Training Program

The following outline of a proposed training program is not the final word in gatekeeper education. It is seen as a transition between two stages: the present situation of very few training programs, and the future, where hopefully, courses in suicide prevention will be an integral part of the education of students in the social services field. The model incorporates what was seen as a valuable learning experience in the form of a conference and a number of occupation- and topic-specific workshops. The focus of this proposed conference and series of workshops will be a sharing of feelings and experiences concerning suicide and suicidal clients. The plan for future gatekeeper education will also need to be flexible to incorporate the specific needs of a specific group of gatekeepers while covering areas of concern that have been indicated as worthy of study. As much as possible the emphasis will be on the local scene. An evaluation component will be a necessary part of such a training program. Such an evaluation might profitably include studying changes in gatekeeper attitudes. The semantic differential ratings of case studies of suicidal people using pre- and post-tests could be employed as a form of training evaluation. If attitudes toward suicidal people changed in a positive direction during training, the benefits of gatekeeper education could be more clearly demonstrated.

The proposed training program would extend over a number of weeks after the initial introductory conference. The people attending the conference and workshops would be self-selected and perhaps even a number of people from one agency could attend different workshops, reporting new skills and broadened resources back to their fellow workers. The general readings that are suggested for such a course are Stengel (1973), for a sound overview of the problem of suicide prevention; the Report (1976), for an outline of the local statistics and planning recommendations; Hatton, et al. (1977), for a good introduction to intervention techniques; this thesis, for an overview of the literature pertaining to various gatekeeper groups; and possibly, Resnik and Hathorne (1973), for an indication of where the field of suicide prevention may be going in the years to come. The following outline will attempt to cover the subject matter of the proposed conference, modelled as it could be after a combination of the January, 1976 and the April, 1977 Conferences for Suicide Prevention held in Edmonton. The medium for information exchange will be varied, combining lectures, small group discussions, films, case presentations, role playing and question and answer sesssions. The subsequent sketch, as well as suggesting topics to be covered at an Introductory Conference, will present the groups to be taught and the topics to be covered in a series of subsequent workshops. Included will be accompanying suggested readings and resource agencies for many of the workshops. These workshops are designed to meet various occupational and multidisciplinary gatekeeper needs in the vast subject area of suicide intervention, prevention and postvention.

Proposed Plan

A. Basic Introductory Conference

1. Focus on nature of the local problem of suicide, giving appriate statistics
2. Introduction to basic concepts involved in understanding the suicidal person's:
   - communication—the "cry for help"
   - ambivalence

- cognitive constriction
- helplessness and hopelessness
- resources

3. Dilemma of the helper
   - own needs
   - influences on attitudes
   - acute-chronic continuum
   - feelings aroused in gatekeeper
   - relationship with suicidal person
   - teamwork/consultation/coordination with other agencies
4. Recognition of the suicidal person
   - verbal, behavioral and somatic clues
   - importance of frank discussion of suicidal feelings
5. Assessment
   - eg. lethality, suicide plan, nature of stresses, resources
6. Crisis Intervention
   - building of relationship
   - exploring alternatives, consequences and resources
   - evaluating and planning
   - implementation of plan
7. Special issues
   - chronicity
   - adolescents
   - follow-up
   - survivors

B. Workshops

1. Specific Groups

A. Volunteers/Crisis Services Workers

- suggested readings: Farberow, Heilig, and Litman (1970); Lamb (1969); Pretzel (1972); Ruiz, et al. (1973)

B. Emergency Ward Staff

- suggested readings: Myerson, et al. (1976); Syer (1975); Welu (1972)

C. Hospital Staff (those involved in direct patient care)

- suggested readings: Beebe (1975); Reynolds and Farberow (1973); Vlasak (1975)

D. Psychotherapists

- suggested readings: Kiev (1977); Light (1976); Litman (1970e); Mintz (1968); Pretzel (1972); Stone (1971)

E. Physicians (Non-psychiatric)

- suggested readings: Kiev (1977); Lewis (1968); Litman (1970b); Shneidman (1970a); Tabachnick (1970)

F. General Staff Nurses

- suggested readings: Farberow and Palmer (1964); Frederick (1973); Leslie (1966); Psyche (1965); Shneidman (1970a)

G. Public Health Nurses

- suggested readings: Bell (1970); Farberow and Palmer (1964); Kloes (1968); Wallace (1967); Wolford (1965)

H. Police

- suggested readings: Litman (1970c); Murphy, et al. (1971); O'Connor (168); Farberow and Shneidman (Note9)

I. Clergy

- suggested readings: Lum (1974); McGee and Hiltner (1968); Stone (1972)

2. Interdisciplinary Topics

   A. Handling own feelings/effects of working with suicidal people

      - influences on attitudes
      - consultation
      - teamwork
      - setting up personal resource network
      - dealing with client suicides

   B. Communication techniques

      - empathic listening
      - reflection
      - clarification
      - active acceptance
      - focusing
      - perception checking

   C. Local referral resources/evaluation of referrals

      - suggested resource person from AID Service of Edmonton

   D. Follow-up

      - suggested readings: Bogard (1970); Paykel, et al. (1974); Weissman, et al. (1973)

   E. Group Therapy

      - suggested readings: Billings, et al. (1974); Comstock and McDermott (1975); Farberow (1968b), 1972c); Weisberg (1974)

   F. Adolescent Suicide

      - suggested readings: Otto (1972); Peck (1977); Rabkin (1978); Solomon and Boldt (Note 1); Ramsay (Note 6)

G. The Elderly and Suicide

- suggested reading: Wolff (1970)

H. Chronically Suicidal

- suggested readings: Bagley, et al. (1976); Farberow (1972b); Wold and Litman (1973, 1977)

I. Volunteerism

- suggested resource agencies: Volunteer Action Center, AID Service of Edmonton

J. Setting up a Workshop/Conference for:

- fellow workers
- community

The preceding suggested topics and groups are by no means limiting. Out of the special needs of the groups being taught may emerge new subject areas, such as community outreach, approaching particularly the native population of Alberta. These additional topics should be encouraged. Similarly, a system of continuing education is needed as literature for use by gatekeepers is expanding at a great rate. The training program, such as that outlined above, will need a central agency to take charge of coordination of the program. As the matter stands now, no agency has the mandate or the resources to begin such a program. It is hoped that in response to increasing pressures, local organizations, in conjunction with various levels of government, can take the lead in much needed suicide prevention work. This suggested training program, should it be implemented, would be a first step in relieving some of the very intense feelings of isolation and frustration experienced by present community gatekeepers.

Implications for Further Research

Many areas mentioned within this study need more extensive development and research. The question of what determinants lead a person to suicide need to be investigated. Are there chains of life events that are precursors to a decision to end one's life? Further, and more specifically for gatekeepers, better methods of management of suicidal clients need to be developed. Presently, for instance, dealing with a chronically suicidal person can often involve a serious time consideration with few observable results. New techniques must be emphasized and explored.

On the local scene, there is a pressing need for accurate statistics. Although a comprehensive survey of completed suicides has been done (Report, 1976), much remains to be accomplished in investigating the problem of attempted suicide. Also, a study of the local population's knowledge of regional social service resources could profitably be undertaken. The results of such a study would indicate present gaps in community care.

With particular references to public and gatekeeper education, many areas exist that could benefit from further research. The present survey has suggested that certain gatekeeper and interactional variables are important in relationships with a suicidal client. Other variables could be explored; one that comes most readily to mind is the proportion of gatekeeper work load that is presently taken up by the chronically suicidal.

Of interest and relevance is the need for additional studies on the evaluation of gatekeeper behavior, and further, the evaluation of the possible change in behavior produced by training. Various directions for research in this area can be seen. Work in evaluating volunteer performance (Powell, et al., 1974; Shneidman, 1976) can be enlarged to include other gatekeeper groups. Or, possibly, already existing systems of observing behavior, such as the Bayles analysis or the McCleish-Martin analysis, could be applied to observations of gatekeeper behavior.

Courses for various gatekeeper groups also need development. Especially desired in this area are training courses adapted to various professional disciplines to be included in the educational experience of students in various occupations, such as nurses, social workers and counsellors. Coupled with this, is the necessity for reaching and influencing public responses to suicide. Education for the general public, using a variety of media, such as the school, community organizations, and parent-teacher associations, must be generated. For, it is only when members of our society achieve their roles as the most natural of community gatekeeepers that constructive social change can occur. Stengel (1973) put it best:

> Today, social work is either a profession or a mission or a hobby. It will have to become part of everybody's daily life if society is to progress not only materially, but also psychologically. The principles, objectives, and techniques of social service will have to be taught side by side with those of science, beginning in the nursery and continuing throughout life. We must match the scientific and technological revolution with as revolutionary a change in social living. (p. 149)

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APPENDIX A

GATEKEEPERS

GATEKEEPERS

The term "gatekeeper" is a very old one, colored by both myth and fact. Biblically, "gates" were very important features of towns. As the Oxford Cyclopedic Concordance (1947) points out:

> The gate of a city was frequently a considerable structure, near which was a public place of assembly, the exchange, court-house, and council-chamber of modern times. Hence the 'gate of a city' was so identified with the life of the community as to be synonymous with the city itself. (p. 142)

This importance attached to a gate is reflected in many biblical passages:

> This gate of the Lord, into which the righteous shall enter. (Ps. 118:20)
>
> Strive to enter in at the strait gate. (Lu. 13;24)
>
> I am the door, by me if any man enter in, he shall be saved. (Jn. 10:9)

It follows then, that a "gate-keeper" held a very important role in being a guardian between what was known (in the city) and the unknown (outside the city and by inference, strangers to the city).

In non-Judaeo-Christian mythology the gatekeeper also occupies a key role. In South American mythology:

> The black man in the cave is a variation of a type of figure known as a threshold guardian of the entrance to a zone of potency or power, the 'gatekeeper.' He is the 'watcher' of the established boundary that marks the passage beyond the veil of the known to the unknown. (Newmann, 1977, p. 49)

Oftentimes "gatekeepers" were not so benevolent. Eliade points out in Shamanism (1964) that a "dog with barred teeth defends the entrance; the dog being dangerous to anyone who is afraid of it"

(p. 295). Further Eliade outlines the "difficult passage" the mythical hero usually faces; the crossing is difficult, often with demons and monsters barring the way. Joseph Campbell (1968) likewise makes reference to encountering "threshold guardians" at the entrance to the zone of increased power, "beyond them is darkness, the unknown, and danger" (0. 77). According to Campbell, the Freudian interpretation of such mythological watchmen or gatekeepers would be the "superego."

However, more to the point, it appears that the term "gatekeeper" was adopted by Snyder (1971) as a term without positive or negative connotations. As he pointed out, the gatekeeper may offer help, may refuse (close the gate) or may give little aid to the troubled person. The objection to the term often comes from a negative value loading to one who can prevent a person from choosing death. After all, many believe the responsilibity for ending one's life should be left with the person making the decision. But as Paul Pretzel (1977) indicated in a thought-provoking article, the assumption of responsibility by the gatekeeper was a needed bias. As he states, "This unquestioning, uncompromising attitude toward suicide had pragmatic value for the task of prevention" (p. 201). The rationale of intervention was based on the emotional depression often accompanying suicide, on the often temporary nature of the crisis and on the often-stated ambivalence of many would-be suicides.

On the other hand, after dealing with many chronically suicidal patients in therapy, Paul Pretzel asked himself, "If I participate in taking away the freedom of that choice from suicidal patients whose peace of mind am I really concerned with?" (p. 202). Further, Pretzel states:

> Just as I would not want my humanity reduced to a simple diagnostic statement, so I would not want to label anyone suicidal and respond as though this were the only significant truth about that person. (p. 204)

These mythological and philosophical considerations are important. However, as the term "gatekeeper" is used in this thesis, it is taken to have neither a positive nor a negative loading. The term refers to a person (be he or she nurse, doctor, minister, wife or husband) in a particular role as a "gatekeeper" who chooses or not, to respond to a suicidal person's cry for help.

APPENDIX B

COVERING LETTER: CONFERENCE GROUP

aid service of edmonton
203, 10711 – 107 AVENUE, EDMONTON, ALBERTA T5H 0W6
INFORMATION/REFERRAL 426-3242 ● DISTRESS LINE 426-4252

Dear Colleague:

In 1976 the Task Force on Suicides in Alberta submitted its report to the Minister of Social Services and Community Health. This report contained data which suggested that gatekeepers in the province had little awareness of the social problem of suicide. You have shown by your participation in this conference that this information is not totally correct.

It is my intention, with your help, to further investigate _your_ response to the problem of suicide in your occupational role. The results gathered from the following questionnaire will become part of my thesis for a Masters Degree in Educational Psychology at the University of Alberta.

It is my hope that the study can be of benefit to you in two major ways. Firstly, the results of the study (when completed) will be made available through AID services of Edmonton. Secondly, the study will represent an expression of some of your feelings and experiences in the area of suicide. The responses to the questions will be used primarily to form an overview of the gatekeepers's role. Each participant's individual responses (as such) will remain confidential.

The questionnaire is divided into four parts. The first section asks for demographic data. The second and third sections deal with your attitudes toward suicide-related concepts. The fourth section surveys your experiences, needs, and recommendations for changes, both present and future, in suicide prevention, intervention, and rehabilitation.

I will be available during this conference to answer any queries that you may have about the study. Please hand in the questionnaire at the registration desk before you leave on Tuesday.

Thank you in advance for your assistance.

Sincerely yours,

Darlene Bayers

Funded by: Preventive Social Service and The United Way of Edmonton

APPENDIX C

COVERING LETTER: WORKSHOP GROUP

aid

aid service of edmonton

203, 10711 – 107 AVENUE, EDMONTON, ALBERTA T5H 0W6
INFORMATION/REFERRAL 426-3242 ● DISTRESS LINE 426-4252

Dear Colleague:

In 1976 the Task Force on Suicides in Alberta submitted its report to the Minister of Social Services and Community Health. This report contained data which suggested that gatekeepers in the province had little awareness of the social problem of suicide. You have shown by your participation in this workshop that this information is not totally correct.

It is my intention, with your help, to further investigate your responses to the problem of suicide in your occupational role. The results gathered from the following questionnaire will become part of my thesis for a Masters Degree in Educational Psychology at the University of Alberta.

It is my hope that the study can be of benefit to you in two major ways. Firstly, the results of the study (when completed) will be made available through AID services of Edmonton. Secondly, the study will represent an expression of some of your feelings and experiences in the area of suicide. The responses to the questions will be used primarily to form an overview of the gatekeepers' role. Each participant's individual responses (as such) will remain confidential.

The questionnaire is divided into four parts. The first section asks for demographic data. The second and third sections deal with your attitudes toward suicide-related concepts. The fourth section surveys your experiences, needs, and recommendations for changes, both present and future, in suicide prevention, intervention, and rehabilitation.

I will be available during this workshop to answer any queries that you may have about the study. If possible please hand in the questionnaire at the registration desk before you leave on Wednesday. If you cannot complete the questionnaire before the end of the workshop please mail it to me, as soon as possible, in the enclosed self-addressed envelope.

Thank you in advance for your assistance.

Sincerely yours,

Darlene Bayers

Funded by: Preventive Social Service and The United Way of Edmonton

APPENDIX D

QUESTIONNAIRE

COMMUNITY GATEKEEPERS OF SUICIDE

DEMOGRAPHIC DATA

On the following page please place a check next to the appropriate answer in questions 1 to 9. For questions 10 to 12 please write in the appropriate response.

1. Sex: M____ F____
2. Marital Status: Single____ Married____ Divorced____
Separated____ Widowed____
3. Race: Caucasian____ Indian____ Metis____
Other (specify)____________________________
4. Age: Under 20____ 21 - 30____ 31 -40____
41 - 50____ 51 - 60____ Over 60____
5. Highest level of education attained: Completed Junior High School____
Completed High School____ University undergraduate degree____
University graduate degree____
Some college or university courses____
Other (specify)____________________________
6. Do you work in a:
____city with a population over 250,000
____city with a population under 250,000
____town
____rural area
____Other (specify)____________________________
7. Are you an Alberta resident? Yes____ No____
8. What is your religious background? Protestant____ Catholic____
Jewish____ Atheist____ Agnostic____
Other (specify)____________________________
9. How religious do you consider yourself to be? Antireligious____
Very religious____ Somewhat religious____
Slightly religious____ Not at all religious____
10. Present Occupation: ____________________________
11. Number of years in present occupation: ______________
12. Number of years of involvement with suicidal people: ______________

SEMANTIC DIFFERENTIAL SCALE

The purpose of the following part of this questionnaire is to measure the meanings of certain concepts by having you judge the concepts against a series of descriptive scales. In judging these concepts please make your judgments on the basis of what these ideas mean to you. On the following four pages of this questionnaire you will find a different concept to be judged and beneath it a set of scales. You are to rate the concept on each of these scales in order.

Here is how you are to use these scales:

If you feel that the concept at the top of the page is very closely related to one end of the scale, you should place your check-mark as follows:

fair__x__:_____:_____:_____:_____:_____:_____unfair

or

fair_____:_____:_____:_____:_____:_____:__x__unfair

If you feel that the concept is quite closely related to one or the other end of the scale (but not extremely), you should place your check-mark as follows:

fair_____:__x__:_____:_____:_____:_____:_____unfair

or

fair_____:_____:_____:_____:_____:__x__:_____unfair

If the concept seems only slightly related to one side as opposed to the other side (but is not really neutral), then you should check as follows:

fair_____:_____:__x__:_____:_____:_____:_____unfair

or

fair_____:_____:_____:_____:__x__:_____:_____unfair

The direction toward which you check, of course, depends upon which of the two ends of the scale seem most characteristic of the concept you're judging.

If you consider the concept to be neutral on the scale, both sides of the scale equally associated with the concept, or if the scale is completely irrelevant, unrelated to the concept, then you should place your check-mark in the middle space:

fair_____:_____:_____:__x__:_____:_____:_____unfair

IMPORTANT: (1) Place your check-mark in the middle of spaces, not on the boundaries:

THIS NOT THIS

____:____:_x__:____:____x____:____

(2) Be sure you check every scale for every concept-- do not omit any.

(3) Never put more than one check-mark on a single scale.

Do not look back and forth through the items. Do not try to remember how you checked similar items earlier in the section. Make each item a separate and independent judgment. Work at fairly high speed through this section. Do not worry or puzzle over individual items. It is your first impressions, the immediate "feelings" about the items, that are most valuable. On the other hand, please do not be careless, because your true impressions are being sought by the researcher.

COMPLETED SUICIDE

good_____:_____:_____:_____:_____:_____:_____bad

pessimistic_____:_____:_____:_____:_____:_____:_____optimistic

positive_____:_____:_____:_____:_____:_____:_____negative

disreputable_____:_____:_____:_____:_____:_____:_____reputable

moral_____:_____:_____:_____:_____:_____:_____immoral

acceptable_____:_____:_____:_____:_____:_____:_____unacceptable

irrational_____:_____:_____:_____:_____:_____:_____rational

LIFE

good_____:_____:_____:_____:_____:_____:_____bad

pessimistic_____:_____:_____:_____:_____:_____:_____optimistic

positive_____:_____:_____:_____:_____:_____:_____negative

disreputable_____:_____:_____:_____:_____:_____:_____reputable

moral_____:_____:_____:_____:_____:_____:_____immoral

acceptable _____:_____:_____:_____:_____:_____:_____unacceptable

irrational_____:_____:_____:_____:_____:_____:_____rational

DEATH

good_____:_____:_____:_____:_____:_____:_____bad

pessimistic_____:_____:_____:_____:_____:_____:_____optimistic

positive_____:_____:_____:_____:_____:_____:_____negative

disreputable_____:_____:_____:_____:_____:_____:_____reputable

moral_____:_____:_____:_____:_____:_____:_____immoral

acceptable_____:_____:_____:_____:_____:_____:_____unacceptable

irrational_____:_____:_____:_____:_____:_____:_____rational

ATTEMPTED SUICIDE

good_____:_____:_____:_____:_____:_____:_____bad

pessimistic_____:_____:_____:_____:_____:_____:_____optimistic

positive_____:_____:_____:_____:_____:_____:_____negative

disreputable_____:_____:_____:_____:_____:_____:_____reputable

moral_____:_____:_____:_____:_____:_____:_____immoral

acceptable_____:_____:_____:_____:_____:_____:_____unacceptable

irrational_____:_____:_____:_____:_____:_____:_____rational

ATTITUDES TOWARD DEATH AND SUICIDE

On the following two pages of the questionnaire please check the answer(s) for each question by the appropriate letter on the reply form.

1. How often have you been in a situation in which you seriously thought you might die?
   - ___A. Many times.
   - ___B. Several times.
   - ___C. Once or twice.
   - ___D. Never.
2. Has there been a time in your life when you wanted to die?
   - ___A. Yes, mainly because of great physical pain.
   - ___B. Yes, mainly because of great emotional upset.
   - ___C. Yes, mainly to escape an intolerable social or interpersonal situation.
   - ___D. Yes, mainly because of great embarrassment.
   - ___E. Yes, for a reason other than above.
   - ___F. No.
3. How often have you seriously contemplated committing suicide?
   - ___A. Very often.
   - ___B. Only once in a while.
   - ___C. Very rarely.
   - ___D. Never.
4. Have you ever actually attempted suicide?
   - ___A. Yes, with an actual very high probability of death.
   - ___B. Yes, with an actual moderate probability of death.
   - ___C. Yes, with an actual low probability of death.
   - ___D. No.
5. Have any of the following people in your life ever committed suicide?
   - ___A. Member of immediate family.
   - ___B. Other family member.
   - ___C. Close friend.
   - ___D. Casual friend.
   - ___E. None of these.

6. How do you estimate your lifetime probability of committing suicide?

    ___A. I plan to do it some day.
    ___B. I hope that I do not, but I am afraid that I might.
    ___C. In certain circumstances, I might very well do it.
    ___D. I doubt that I would do it in any circumstances.
    ___E. I am sure that I would never do it.

7. Suppose that you were to commit suicide, what reason would most motivate you to do it?

    ___A. To get even or hurt someone.
    ___B. Fear of insanity.
    ___C. Physical illness or pain.
    ___D. Failure or disgrace.
    ___E. Loneliness or abandonment.
    ___F. Death or loss of a loved one.
    ___G. Family strife.
    ___H. Atomic war.
    ___I. Other (Specify)________________________________

8. Suppose you were to commit suicide, what method would you be most likely to use?

    ___A. Barbiturates or pills.
    ___B. Gunshot.
    ___C. Hanging.
    ___D. Drowning.
    ___E. Jumping.
    ___F. Cutting or stabbing.
    ___G. Carbon monoxide.
    ___H. Other (specify)________________________________

EXPERIENCES, NEEDS AND RECOMMENDATIONS

On the following pages please give your best estimate when numbers and percentages are required. If you need more space to respond to individual questions please use the backs of the pages.

1. How many completed suicides do you know of in your community within the:

   last month?_____

   last year? _____

2. What aspect of suicide are you presently primarily engaged in (check one)?

   _____prevention

   _____intervention

   _____post-vention (rehabilitation)

3. Do you primarily work with one age group? Yes_____ No_____
   If you responded yes, which group? youths (to age 18)_____
   adults_____ elderly (65 and over)_____

4. What are your methods of contact with suicidal people?

   _____face to face % of time______

   _____telephone % of time______

   _____other (specify)__________________ % of time______

5. How do you usually first come into contact with a suicidal person in your occupational setting?

   _____self-referral

   _____referred from another agency

   _____referred by family or friend

   _____other(s) (specify) ____________________________________

6. Describe briefly the usual procedure you presently employ when you come into contact with a suicidal person in your occupational role?

   ____

   ____

   ____

7. Is it your present policy to refer the suicidal person to an alternate person or agency in your community? Yes_____ No_____

If you responded yes, please name such agency or person.

____

____

8. Is there presently in your community an agency or person that you would feel comfortable referring a suicidal person to? Yes_____ No_____

If you responded yes, please name such agency or person.

____

____

9. How many suicidal people would you talk to in your occupational setting during:

a week ______? a month_____? a year______?

10. Approximately what percentage of your total work load would include dealing with suicidal people? ______%

11. How many of the above people (per month) would have:

_____suicidal thoughts but have taken no actions?

_____made suicidal attempts?

12. Identify one primary emotion you have in your work role when you:

first come into contact with a suicidal person__________________

____

have left the interview____

____

13. Have any of the suicidal people that you have dealt with in your occupational role committed suicide subsequently or during treatment?

Yes_____ No_____

If you responded yes, what was your emotional reaction when you found out about the suicide? ________________________________

14. What is your policy in regards to follow up of suicidal people who are:

referred to another person or agency? ___________________________

____

discharged from your care?

15. What are the main needs of the suicidal person?

Which of these needs do you feel you are meeting?

Which of these needs do you feel you are not meeting?

16. How could your present agency/community resources be used more effectively and efficiently to meet the needs of the suicidal person in:

prevention?

intervention?

rehabilitation?

17. What are your needs in connection with the suicidal person that are being met:

in relation to your job?

in a personal sense?

18. What are your needs in connection with the suicidal person that are not being met:

in relation to your job?______________________________

____

in a personal sense?______________________________

____

19. Are there any pieces of literature in the area of suicide and suicide prevention that have been especially helpful to you in your work?

Yes_____ No_____

If you responded yes, what are they?______________________________

____

20. How do you think high-risk suicidal sub-groups in your community could be reached more effectively:

with present resources?______________________________

____

if more resources were available?______________________________

____

21. Would you be willing to keep records of your contacts with suicidal people to send to a central data bank for research purposes?

Yes_____ No_____ Only under certain conditions_____

Why or why not, or under what conditions? ______________________________

____

22. Do you believe that people not specifically educated and trained should be involved in programs of suicide intervention and prevention?

Yes_____ No_____

23. Are volunteers presently an integral part of your agency functioning?

Yes_____ No_____

If you responded yes, how are they presently used?______________________________

____

If yes or no, how could they be used in future work with suicidal people?____

____

24. Do you feel that a Suicide Prevention Center is needed in Alberta?

Yes_____ No_____

If yes, what would be the major resources that you would expect a Suicide Prevention Center to provide:

to you personally?______________________________________

____

to you in your occupational role?__________________________

____

to your agency?____

____

to your community?_______________________________________

____

(eg. 24 hour telephone service, speakers for community organizations, resources for referrals, consultation, education, therapy (short and long term), a mobile unit, coordination for community resources, research, in and out patient psychiatric facilities.)

25. Do you feel further training in the area of suicide prevention should be directed to (check one):

_____your occupational group?

_____an interdisciplinary group?

26. Will you be disseminating the knowledge and skills gained at this workshop/conference to your:

fellow workers? Yes_____ No_____

community? Yes_____ No_____

If you responded yes, how?____________________________________

____

____

27. Can you identify one major feeling, now that you have answered this questionnaire? ______________________________

____

28. Please include any additional comments/reactions that you feel are needed.

____

____

____

____